

00-05125

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 0 0 6  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		MIN.	
JULIET		Proctor		OWINGS				4/28/86								8 40		M	
3. SEX		4. RACE		5. DATE OF BIRTH		MONTH		DAY		YEAR		6. AGE		(IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		Apr. 22, 1899								87		YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
VA		USA						BALTIMORE CITY										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
BALTIMORE		UNION MEMORIAL HOSPITAL		Homemaker		Own Home													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE											
MD				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		30 Hamill Ct., 21210											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
DeWitt		Walter		Proctor		Sallie		Perry		Johnston									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		217 48 4655		Charles Goldsborough,		MD													

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra cerebral hemorrhage</u>			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) _____			
DUE TO, OR AS A CONSEQUENCE OF			
(c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>cerebral vascular disease</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>4/23/86</u> , 19 <u>86</u> , to <u>4/28</u> , 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>4/28</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
<u>Mertine R. Jernany MD</u>		<u>4/28/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
MERTINE R. JERNANY		UNION MEMORIAL HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Cremation		4/29/86	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Green Mount		Balto., MD	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212		APR 29 1986	
		25b. REGISTRAR'S SIGNATURE <u>J. Davidson</u>	

BP

TO HOSPITAL CENSUSING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The original certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

Female  
 White  
 Apr. 20, 1869  
 57  
 USA  
 Baltimore  
 30 Hamilton St.,  
 Baltimore  
 John P.



Green House  
 Henry W. Johnson & Sons Co.  
 125 York Road  
 Baltimore, Md. 21112  
 Baltimore, Md.



0-02961

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 0 0 8  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		10:45AM	
FIRST MIDDLE LAST		April 7, 1986			
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		White		MONTH DAY YEAR	
				3 7 1897	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
Baltimore		Maryland General Hospital		Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		Maryland General Hospital		Never Employed	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE	
Maryland		Baltimore		Catonsville 615 Aldershot Road, 21229	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Henry J.S. Owings, Sr.		Mabel UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212-56-9359		Elfrieda J. Gray, 1417 Langford Road, 21207	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia/Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <del>XXXXXX</del> attended the deceased from <u>3/27</u> , 19 <u>86</u> , to <u>4/7</u> , 19 <u>86</u> , that (I) <del>XXXXXX</del> last saw the deceased alive on <u>4/7</u> , 19 <u>86</u> , and that in (my) <del>XXXXXX</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>XXXXXX</del> (did) <del>XXXXXX</del> view the body after death.					
22b. SIGNATURE <u>La Rondelle</u>				22c. DATE SIGNED <u>4-7-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>La Rondelle</u>				22e. ADDRESS <u>c/o Maryland General Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		4/10/86		Security Process Crem.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hubbard Funeral Home, Inc., 4107 Wilkens Ave.		21229		APR 09 1986	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed, the 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

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Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

20% COTTON FIBRE

00-03979

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 4 0 0 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Florence W. Pabst</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 13, 1986</b>			2b. HOUR <b>7:00 P.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 17, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1728 E. Belvedere Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>City</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1728 E. Belvedere Ave. 21239</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Woolcott</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah E. Frederick</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				
16b. SOCIAL SECURITY NO. <b>219-14-2167</b>			17. INFORMANT ADDRESS <b>Timonium, Md.</b>			17. INFORMANT ADDRESS <b>Milton Zavadil, Jr. -219 Eastspring Rd. 21093</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>hypertensive cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4/13/86</b> <b>10 yrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>June 19 84</b> to <b>April 19 85</b> , that (I) (we) last saw the deceased alive on <b>4/12 19 86</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Allen Kimmel</b>			DEGREE <b>MD.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/14/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Allen Kimmel M.D.</b>			22e. ADDRESS <b>220 W. Cold Spring Lane, Baltimore, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4-16-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville, Balto., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>			24. FUNERAL DIRECTOR ADDRESS <b>1050 York rd.</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 18 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



00-06754

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then place in separate carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on scene.

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 0 1 0

1. DECEASED NAME (TYPE OR PRINT) <b>James Page</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 12, 1986</b>		2b. HOUR M
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 6 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1934 E. Lafayette Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRODUCE TERMINAL</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MOTON PAGE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MAMIE BROOKINS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215073349</b>		17. INFORMANT ADDRESS <b>AMY PAGE 1934 E. LAFAYETTE AVE.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MULTIPLE MYELOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 years</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0 minutes</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CACHEXIA, DEMENTIA, PARAPARESIS, PROSTATE CANCER</b>					
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <b>July 1</b> , 19 <b>84</b> , to <b>May 12</b> , 19 <b>86</b> , that (1) (we) lost saw the deceased alive on <b>April 22</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Kenneth J. Holroyd MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>5-12-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KENNETH J. HOLROYD</b>		22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL BALTIMORE MD 21205</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5-17-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MARYLAND NATIONAL</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>LAUREL MARYLAND</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>March Funeral Homes 1101 E North Ave.</b>			
25a. DATE REC'D. BY REGISTRAR <b>MAY 16 1986</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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MAY 18 1900

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

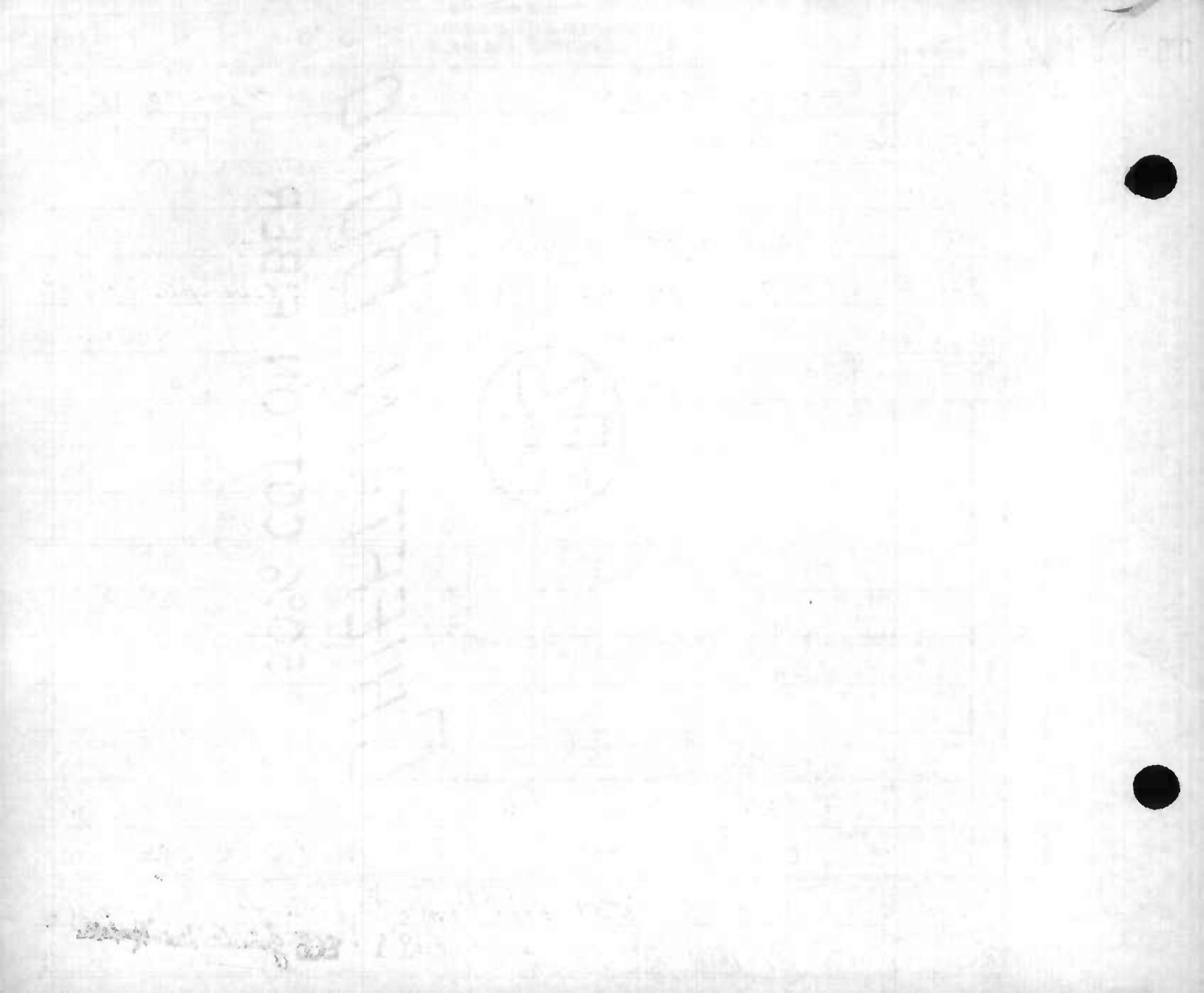
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-05352

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8614011	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) MARY ETHEL PAGE					2a. DATE OF DEATH MONTH DAY YEAR 4/26/86			2b. HOUR 6 <sup>15</sup> A.M.			
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 5/8/1910		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.					
10. CITY OR TOWN OF DEATH BALTO. MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VILLA OF ST. MICHAEL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BEAUTICIAN		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE BALTO		13b. CITY OR TOWN BALTO.		13c. CITY OR TOWN MARYLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4400 BELLE AVE 21267			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM WOODLAND				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie YOUNG							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-16-5307		17. INFORMANT ADDRESS Charles Page 4400 Belle Ave							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory Arrest.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Coronary Artery Disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease.</u> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> 19 <u>86</u> , to <u>April 26</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>April</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Ruben Reidner</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/30/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN REIDNER MD				22e. ADDRESS 914 N. Charles Street Balto.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-1-86		23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME Bailey-Douglas						ADDRESS 1348 N. Calhoun St		25. DATE REC'D BY REGISTRAR MAY 1 1986			





MEDICAL CERTIFICATION

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

24 FUNERAL DIRECTOR  
**Schlmunek**



RECEIVED  
JAN 11 1964  
FBI  
WASHINGTON



00-05725

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 4 0 1 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BABY BOY PALMER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 23 86</b>			2b. HOUR <b>4:45 PM</b>				
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 23 86</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>2 0</b>		IF UNDER 1 YEAR IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSP. INC.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NEW BORN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5503 BELAIR RD. 21206</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>BRYAN PALMER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KAREN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>HOSP. RECORD</b>			17. INFORMANT ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1 IMMATURITY - 20 WEEK</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PREMATURE LABOR</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GESTATION</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>LIFE</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 23, 19 86</b> to <b>APRIL 23, 19 86</b> , that (I) (we) lost saw the deceased alive on <b>APRIL 23, 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (s) (d) (s) (d) not see the body after death.										
22b. SIGNATURE <b>Ronald L. Gutberlet</b>					DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/23/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RONALD L. GUTBERLET</b>					22e. ADDRESS <b>MERCY HOSP, INC.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>5-1-86</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>					ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 05 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP

2222

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00-08102

FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 0 1 4  
REG. NO.

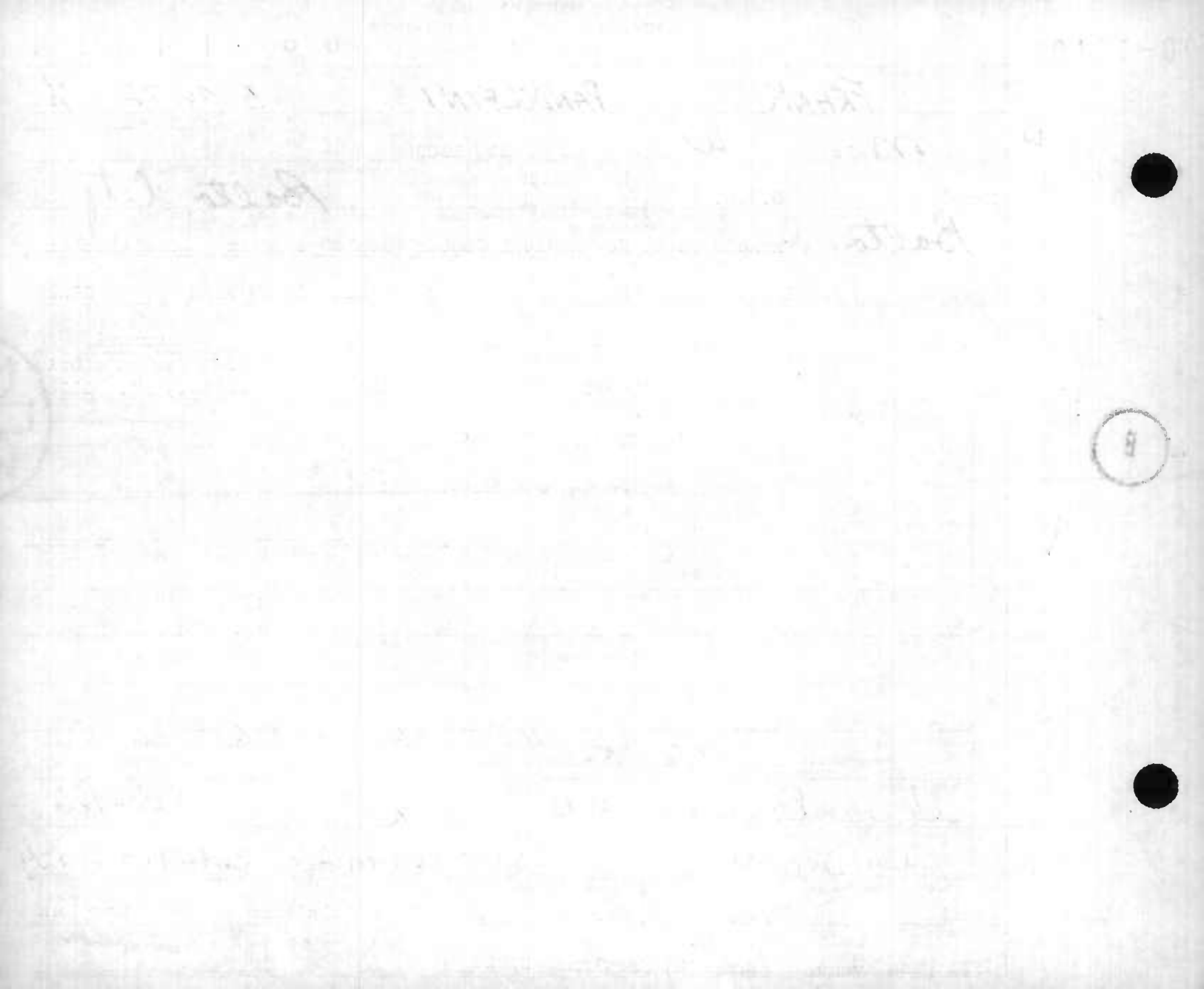
1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>FRANK</b>		MIDDLE	LAST <b>PANDOLFINI</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>5 26 86</b>		2b. HOUR <b>10 A M</b>	
3 SEX <b>male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 21 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto City MD</b>				
10. CITY OR TOWN OF DEATH <b>Balto</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tool&amp;Dye Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Black&amp;Decker</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>1222 Willow Road 21222</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Not Known</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mamie Bucarri</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-10-9810</b>		17. INFORMANT <b>Tony Pandolfini</b>		ADDRESS <b>4340 Parkside Drive Balto., MD. 21206</b>				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Exacerbation of COPD</b> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>1/13</b> , 19 <b>86</b> , to <b>5/26</b> , 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>5/26</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Susan Denman M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/29/86</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Susan Denman</b>		22e. ADDRESS <b>5200 Eastern Ave Balt Md 21224</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/30/ 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens Of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>		ADDRESS <b>7922 Wise Avenue Dundalk, Maryland 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 2 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 0 1 5  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>EDNA M. PARIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 6 1986</b>			2b. HOUR M <b>M</b>			
1. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 26 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>70</b>	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>622 S. MILTON AVE.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>622 S. MILTON AVE. 21224</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD W. SZAMBORSKI</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH KNUCIAK</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214 01 7119</b>		17. INFORMANT ADDRESS <b>EDWARD SZAMBORSKI 608 S. MILTON AVE.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-Vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/5- 1981</b> to <b>5/6 1986</b> , that (I) (we) last saw the deceased alive on <b>4/8/86</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Joseph R. Liberto</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/6/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH R. LIBERTO, M.D.</b>			22e. ADDRESS <b>3508 BANK ST, Baltimore MD 21214</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>MAY 9 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>		
24. FUNERAL DIRECTOR NAME <b>RAYMOND L. KACZOROWSKI</b>			ADDRESS <b>2525 FREET ST.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 8 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

BP

00-05936

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/interment permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 4 0 1 6  
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
**AFTER DEATH,** WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 500 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 500 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**PAGE 4** SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS FORM. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 500 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				1 4 0 1 6 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH DAY YEAR		2b. HOUR	
ANNIE		M.				PASTOR		<input checked="" type="checkbox"/> MONTH DAY YEAR		5 8 19 86		M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
Female		White		6-8 1913		72				5 8 19 86		8:55 P M	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Ind.		U.S.A.		WIDOWED		DIVORCED		Baltimore City				MD	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		14b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		1228 Washington Blvd.		Housewife		at home							
15a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		16a. COUNTY		17. CITY OR TOWN		18. INSIDE CITY LIMITS?		19. STREET ADDRESS					
Ind.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1228 Washington Blvd.					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Archibald P. Dougherty		Elizabeth Sexton		20-09-2301		Christyhn Paul Astor		3717 McDowell Lane					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. (IF YES, GIVE WAR OR DATES)											
No													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Hypertensive & arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
		DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF									
		(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED									
Ann M. Dixon		Assistant		5-9-86									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
Ann M. Dixon, M.D.		111 Penn St., Balto., MD		21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Buried		5-12-1986		Cedar Hill Cem.		Ct Co Ind.							
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
J. Comon, Jr. Inc. 901 Hallway St.		MAY 14 1986		Julia Davidson-Rodette									



5-20-11

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-08011

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH *AKA*

REG. NO.

86 14017

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mozella Pate</i>		2a. DATE OF DEATH MONTH DAY YEAR May 24, 1986		2b. HOUR M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 20 19	
6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.		10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITIAN HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13b. COUNTY Maryland		13c. CITY OR TOWN Baltimore		13d. STREET ADDRESS / ZIP CODE 1310 Walters Avenue 21239	
14. FATHER'S NAME FIRST MIDDLE LAST John Pate		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nathelma Jennings		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (NO OR UNKNOWN)	
16b. SOCIAL SECURITY NO. 212-12-7590		17. INFORMANT Barbara Pate		ADDRESS 1310 Walters Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ventricular Fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>End stage Renal disease</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>1 hour</i> <i>1 year</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Diabetes mellitus, hypertension, previous cardiac arrest in 3/86</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <i>3:45pm 5/24 19 86</i> , to <i>4:20p 5/24 19 86</i> , that (I) (we) last saw the deceased alive on <i>3:45pm 5/24 19 86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Michael N. Drossner</i>		DEGREE MO		22c. DATE SIGNED 5/24/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL N. DROSSNER		22e. ADDRESS 600 N. Wolfe St. Baltimore MO 21205		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 5/30/86		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
23d. LOCATION Baltimore, COUNTY Md. STATE		24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Homes 1101 East North Avenue			
25a. DATE REC'D. BY REGISTRAR MAY 29 1986		25b. REGISTRAR'S SIGNATURE <i>John L. ...</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



COPIES OF THIS PUBLICATION



00-06004

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 14018  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JASPER		FIRST MIDDLE LAST PATTERSON, JR		2a. DATE OF DEATH MONTH DAY YEAR 5 2 86		2b. HOUR 5:01 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 03 15 15		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Cty MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK OR SOURCE OF WORKING LIFE) PORTER		12b. KIND OF BUSINESS OR INDUSTRY Gas & BALTO. Electric	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore Cty		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jasper Patterson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Robinson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.			
16b. SOCIAL SECURITY NO. 213-09-5773		17. INFORMANT Hattie L. Speights 1630 N. Bentalou Street Beatrice Patterson Baltimore, Md. 21216					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Liver failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-10 minutes 1 week							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/1 19 86 to 5/2 19 86, that (I) (we) lost saw the deceased alive on 5/1 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. J. Metz MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/2/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Metz MD		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/7/1986		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL HOME, INC. NAME ADDRESS 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216				25a. DATE REC'D. BY REGISTRAR MAY 8 1986		25b. REGISTRAR'S SIGNATURE John Darden	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



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200-101100-100

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100-101100-100

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE COMPLY WITH ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. IN EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF A SIGNATURE. ALONG WITH FORM #1, RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS OF RECEIVING THE CERTIFICATE. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS OF RECEIVING THE CERTIFICATE.

**TO STATE DEPARTMENT OF HEALTH AND GENERAL HYGIENE, DIVISION OF VITAL RECORDS:** 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVAL

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5)  
20M 4/82

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										14019 REG. NO.																																																																																									
1. DECEASED NAME (TYPE OR PRINT) VERNETTA										2. DATE KNOWN OF ESTI- DEATH MATED 5 4 19 86										2b. HOUR M 7:10 A																																																																																									
3. SEX Fem										4. RACE Col										5. DATE OF BIRTH MONTH DAY YEAR 10 31 17										6. AGE (IN YEARS) LAST BIRTHDAY 68 YRS.										7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.										8. IF UNDER 24 HRS.										9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City										10. CITY OR TOWN OF DEATH Baltimore										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1926 W. Franklin St.										12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic										12b. KIND OF BUSINESS OR INDUSTRY									
13. STATE Md.										13b. COUNTY										13c. CITY OR TOWN Balto										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS 1926 W. Franklin St-21223																																																																					
14. FATHER'S NAME FIRST MIDDLE LAST George Patterson										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Genera Brooks										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO. 115-10-2496										17. INFORMANT Mr. Milton Brooks-21223										ADDRESS 1215 W. Mulberry St																																																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																																																																																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																																																									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																																																									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																																																																																									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 5-4-86																																																																																									
ACTUAL SIGNATURE Ann M. Dixon, M.D.										ADDRESS 111 Penn St., Balto., MD 21201																																																																																																			
23a. BURIAL, CREMATION, REMOVAL (COPY IF)										23b. DATE 5-9-86										23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn										23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.																																																																															
24. FUNERAL DIRECTOR NAME Charles H. Powell-1206 W. North Ave 21217										25a. DATE REC'D. BY REGISTRAR MAY 8 1986										25b. REGISTRAR'S SIGNATURE Julia Davidson																																																																																									



00-08251

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 4 0 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LILLIAN M. PEACOCK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>05 29 86</b>		2b. HOUR <b>10<sup>00</sup> AM</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 02 99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Charles General 21218</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>--</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4458 LaPlata Ave. 21211</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Vincent J. McClain</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha S. Kexel</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-09-8890</b>	
17. INFORMANT ADDRESS <b>Patricia Nasser 4458 LaPlata Ave. 21211</b>									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC OBSTRUCTIVE LUNAR DISEASE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>CONGESTIVE HEART FAILURE, DIABETES, STOMACH'S ULCERS</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4-18-86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) <b>--</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>19</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>---</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>4-18-86</b> to <b>5-29-86</b> , that (I) (we) last saw the deceased alive on <b>5-29-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Sudhir D. Patel</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>5-29-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SUDHIR D. PATEL</b>				22e. ADDRESS <b>NORTH CHARLES GEN. HOSP.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/2/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>A. Alan Seitz, Jr.</b>				ADDRESS <b>3818 Roland Ave. 21211</b>		25a. DATE REC'D BY REGISTRAR <b>JUN 2 1986</b>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the remains. The medical examiner must be notified by page 3.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14021

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LORRAINE PERKINS</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>MAY</b> YEAR <b>86</b>			2b. HOUR <b>M</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>4</b> YEAR <b>17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Burke Secours Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Food handler</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>HORACE</b> MIDDLE <b>GREEN</b> LAST <b>GREEN</b>			15. MOTHER'S MAIDEN NAME FIRST <b>MAUDE</b> MIDDLE <b>IRBY</b> LAST <b>IRBY</b>			13e. STREET ADDRESS / ZIP CODE <b>3010 Auchentray Place 12121</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Chart</b> ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>BACTEREMIA - CHOLANGITIS</b> (c) <b>PANCREATIC - Biliary disease</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ACUTE RENAL FAILURE</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>30 APRIL 1986</b> to <b>12 MAY 1986</b> , that (I) (we) lost saw the deceased alive on <b>11 MAY 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Curtis E Davis</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CURTIS E DAVIS</b>						22e. ADDRESS <b>Burke Secours Hosp</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5-15-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Artichus Mem.</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Chesapeake Manor</b>		
24. FUNERAL DIRECTOR NAME <b>E.L. Phillips</b> ADDRESS <b>1721 N. Monmouth</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 13 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John T. ...</b>	

20% COTTON FIBER  
DEBIT NOTICE

CHIEF OF POLICE

CHIEF OF POLICE



Page 30-3



00-07226

3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The local registrar requires that the physician certify that the deceased was examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician, it should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

BP

DHMM - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR			REG. NO. 8614022							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES C. PERRY						2a. DATE OF DEATH MONTH DAY YEAR MAY 15, 1986			2b. HOUR A 4:40 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 26 24		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Officer		12b. KIND OF BUSINESS OR INDUSTRY Coast Guard		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? 3909 Southern Ave.		13e. STREET ADDRESS / ZIP CODE 3909 Southern Ave. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel -- Wilhelm					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII 445-16-9226		17. INFORMANT ADDRESS Mrs. Angela Perry - Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral anoxia DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Renal cell Carcinoma									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > 5 minutes 5-10 minutes 2/86-5/15/86	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 5/12 1976 to 5/15 1986, that (I) (we) lost saw the deceased alive on 5/15 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Shanta Purcell					DEGREE			22c. DATE SIGNED 5/15/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Shanta Purcell					22e. ADDRESS 600 N. WOLFESTREET-BALTO. MD. 21205 Johns Hopkins Hospital Baltimore.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 5-16-86		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board					ADDRESS Balto., Md.			25a. DATE REC'D. BY REGISTRAR MAY 21 1986		
								25b. REGISTRAR'S SIGNATURE Jana Davidson-Purcell		

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

100-111111

100-111111  
JAN 15 1964  
FBI - NEW YORK

2 2 2

00-06148

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14023

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James D. Perry			2a. DATE OF DEATH MONTH DAY YEAR 4/30/86		2b. HOUR 12:00AM		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 30 24		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. City MD.	
10. CITY OR TOWN OF DEATH Balt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ of Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) VET		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD				13b. COUNTY Balt		13c. CITY OR TOWN Balt	
14. FATHER'S NAME FIRST MIDDLE LAST George Perry				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Malissa Griffin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-205472		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Resp arrest DUE TO, OR AS A CONSEQUENCE OF (b) sepsis DUE TO, OR AS A CONSEQUENCE OF (c) liver disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 2 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Cardiomyopathy							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/22, 19 86, to 4/30, 19 86, that (I) (we) last saw the deceased alive on 4/29, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. Rosen MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Rosen		22e. ADDRESS 22 S. Greene St					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 5-5-86		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				25a. DATE REC'D. BY REGISTRAR MAY 13 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

NOTICE FOR

PAID TO ORDER



8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove the tag attached to the bottom of the certificate and forward it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. **IMPORTANT:** If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

DMMH 10-60M 7-84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 86 14024							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY Ida PHANEUF						2a. DATE OF DEATH MONTH DAY YEAR MAY 20, 1986		2b. HOUR 9:44AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 13 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE California						13b. COUNTY		13c. CITY OR TOWN San Diego	
14. FATHER'S NAME FIRST MIDDLE LAST Franklin Henry Cooper		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Lena Carol		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4235 Lochlomond Street 92111			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220-07-8866		17. INFORMANT Clyde W. Snyder		ADDRESS Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MULTIPLE MYELOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>PLEURAL EFFUSION</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 6</u> , 19 <u>86</u> , to <u>MAY 20</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>MAY 20</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) did not see the body after death.									
22b. SIGNATURE Muhees Adeola				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/20/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Muhees Adeola				22e. ADDRESS CHURCH HOSPITAL CORP. 21231 100 NORTH BROADWAY BALTIMORE, MMD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/24/1986		23c. NAME OF CEMETERY OR CREMATORY Hagersville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagersville Arkansas			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, Maryland 21222				25a. DATE RECD. BY REGISTRAR MAY 21 1986		25b. REGISTRAR'S SIGNATURE John Anderson-Randall			





Items 5&amp;6 6/2/86 mtb

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GLADYS CHRISTINA PHILIP			2a. DATE OF DEATH MONTH DAY YEAR MAY 17 1986			2b. HOUR 12:30 P M	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 7 13 83		6. AGE (IN YEARS LAST BIRTHDAY) 83 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Florida		13b. CITY OR TOWN Madiera Beach		13c. STREET ADDRESS / ZIP CODE 738 Pruitt Drive 99999			
14. FATHER'S NAME FIRST MIDDLE LAST John Wildgoose		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabella Trail		16. ADDRESS 21136			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 009-16-0627		17. INFORMANT Sandra Philip 500 Deaconbrook Cir.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory failure/arrest 10 min DUE TO, OR AS A CONSEQUENCE OF (b) Disseminated intravascular coagulation 3 days DUE TO, OR AS A CONSEQUENCE OF (c) Gastric Cancer, metastatic 5 yrs.							APPROXIMATE INTERVAL - BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Malnutrition							
19a. DATE OF OPERATION 4/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastric Cancer			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/12 19 86 to 5/17 19 86, that (I) (we) last saw the deceased alive on 5/17 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.)							
22b. SIGNATURE Thomas Gross				DEGREE MD		22c. DATE SIGNED 5/17/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Gross				22e. ADDRESS JHH			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5-18-86		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Cremation Society of Md. Inc. Balto. Md				25a. DATE REC'D. BY REGISTRAR MAY 19 1986			
				25b. REGISTRAR'S SIGNATURE L. K. K. K.			

00-06971

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. It may be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please have copies of pages 1 and 2 of this certificate filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified for a necropsy.

DMMH - 16-00M 7/84  
(VERA 15, 4)

1. Name of plant or animal  
2. Name of collector  
3. Name of collector  
4. Name of collector

X

1912

1912

1912

X

H.H.

1912



00-06966

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 4 0 2 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) A. AUDREY M. PHILLIPS			2a. DATE OF DEATH MONTH DAY YEAR 5 17 86			2b. HOUR 6 <sup>04</sup> P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 17 15		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nursing Aid	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Martin Hum				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Hubbard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-30-3454		17. INFORMANT ADDRESS Louis G. Phillips 1327 Linden Ave. 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock that led to Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Possible myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Sepsis - 2° to Urinary Tract Infection</u>							
19a. DATE OF OPERATION <u>NA</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>NA</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>—</u>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-15</u> , 19 <u>86</u> , to <u>5-17</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5-17</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Surjit Tjuka</u> <u>F.A. Hamilton M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5-17-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Surjit Tjuka, M.D.</u> <u>F.A. Hamilton M.D.</u>				22e. ADDRESS <u>Bon Secours Hospital</u> <u>2000 W. Baltimore St. Baltimore, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/20/86		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.				ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR MAY 19 1986	
25b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the certificate and page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

REPT. NO. 100-1115

REPT. NO. 100-1115

212

0-07552

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

8 013 82 09

TO HOSPITAL OR ATTENDING PHYSICIAN: The deceased's death was certified by the attending physician. The physician's name and address should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 19, shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 4 0 2 7 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Elise Licefi Picinotti</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 23, 1986</b>				2b. HOUR <b>6:05 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 20, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Edgewood</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2011 Pulaski Highway 21040</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jimmy Dacre</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eleanor</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>214-24-5063</b>		17. INFORMANT ADDRESS <b>Mr. Clement H. Picinotti Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPTISEMIA, ISCHEMIC BOWEL</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>URINARY INFECTION</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 min</b> <b>3 days</b> <b>≈ 10 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19 05/18</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>05/23/86</b> to <b>05/27/86</b> , that (I) (two) lost saw the deceased <b>above</b> , (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>[Signature]</b>				DEGREE				22c. DATE SIGNED <b>05/27/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALICIA TOGIA</b>				22e. ADDRESS <b>Dept. of Medicine, 1144</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>May 27, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 26 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

BP

Edward J. Kane, Jr., Baltimore, Maryland

02/15

2524

405-1344/ 1255.04

22/2/21 22/2/21 22/2/21

*[Faint handwritten notes]*

• **Yves Morin**

0-07666

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14028

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GERTRUDE PIELERT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 23 86</b>			2b. HOUR <b>2:30 PM</b>				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 17 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH CHARLES GEN. HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SEAMSTRESS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TAILORING</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE <b>MD.</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>422 N. MONTFORD AVE. 21224</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>CASPER SANDLER</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY WEIMAN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214 05 3599</b>		17. INFORMANT ADDRESS <b>Mrs. Dolores Cole - 9700 Liberty Rd. 21133</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>URINARY SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Wks</b> <b>days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF INJURY, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this (hospital) attended the deceased from <b>August 10 1977</b> to <b>23 May 1986</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased on <b>23 May 1986</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> (we) did not view the body after death.										
22b. SIGNATURE <b>[Signature]</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>5/23/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR M. LEBSON</b>					22e. ADDRESS <b>3600 Fords Lane Balto MD 21215</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>5-27-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Barth Miller - 2334 Jefferson St.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 27 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP \_\_\_\_\_



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 0 2 9  
REG. NO.

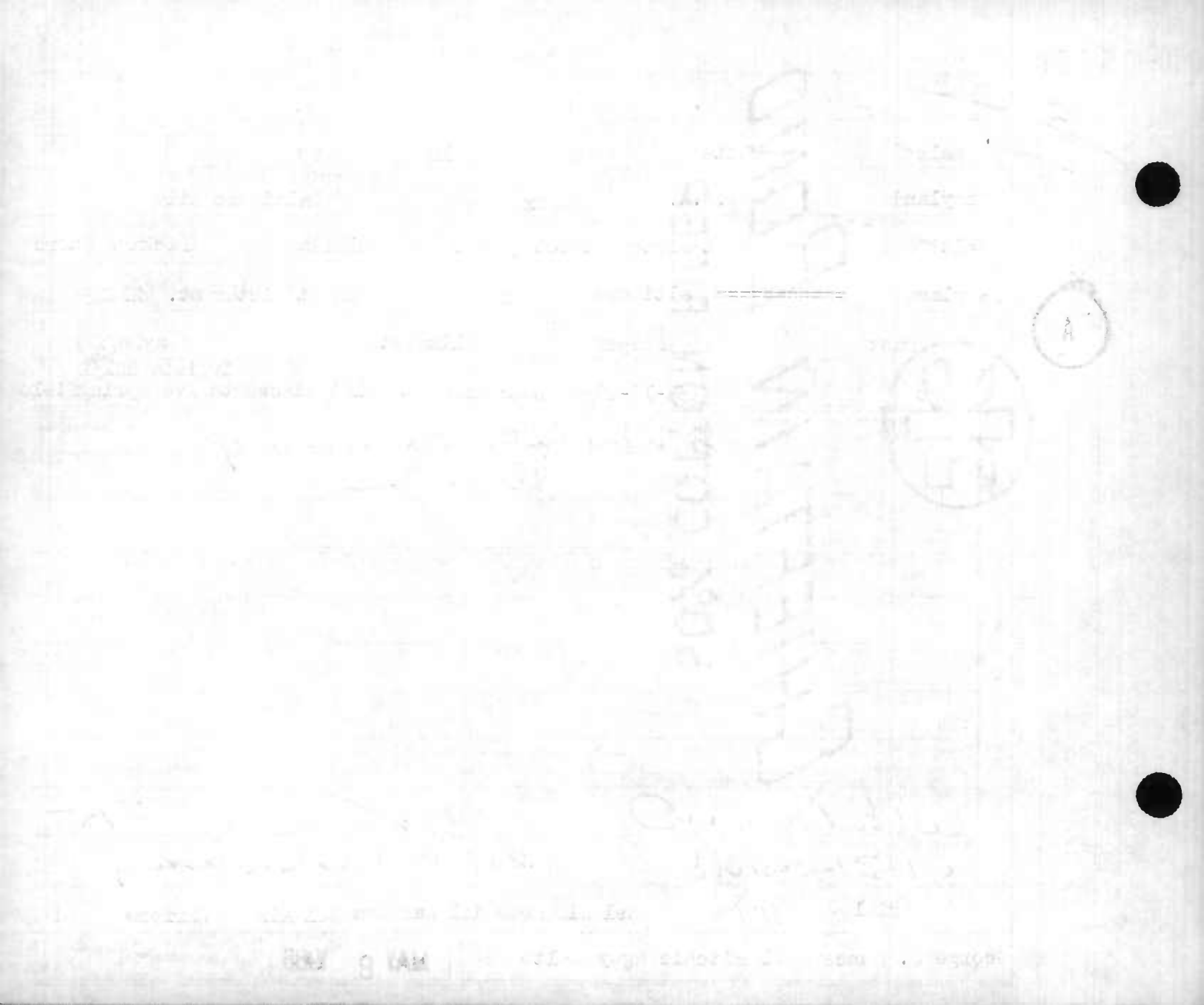
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		Thomas H. Pieper		May 5, 1986		2:55A <sub>M</sub>	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		8 MONTH 3 DAY 12 YEAR		73 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		3622 St Victor Street ( Home )		Salesman		Package Store	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS / ZIP CODE			
Frank Pieper		Elizabeth Dayhoff		3622 St Victor St. 21225			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
No		553-10-2354		Lois Badolato		Virginia 22152 8106 Ainsworth Ave Springfield	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma of</i> DUE TO, OR AS A CONSEQUENCE OF <i>R colon</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
<i>W. B. Howard</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		5/5			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
W. B. Howard		201 E. Lewis Rd					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		5/7/86		Bel Air Memorial Gardens		Bel Air Harford Md	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George J. Gonca 4001 Ritchie Hwy Balto Md				MAY 8 1986		<i>John J. Gonca</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the reverse side, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be called at once.)

MEDICAL CERTIFICATION





-08185

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (Type in full) <b>Pilleris KAY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5 27 86</b>			2b. HOUR <b>9 05 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 5 97</b>		6. AGE (In years last birthday) <b>89</b>		6. AGE (If under 1 year) MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (State or foreign country) <b>Greece</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City Md.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) <b>VA Medical Center Balt Md</b>				12a. USUAL OCCUPATION (Type of work for most of working life) <b>Restaurateur</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Spiro Pilleris</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates) <b>Yes WWII</b>			
16a. SOCIAL SECURITY NO. <b>213-16-5905</b>			17. INFORMANT Mrs. Elizabeth Mayroulis 9687 Church Way, Burke, Va. 22015			17. ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cirrhosis and Liver Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>~ 1/2 hour</b> <b>Unknown</b> <b>Unknown</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Renal Failure</b>									
19a. DATE OF OPERATION <b>5-12-86</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Duodenal perforation</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner.)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in item 18 Part 1 or Part 2) <b>None</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5-12</b> , 19 <b>86</b> , to <b>5-29</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5-29</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.)									
22b. SIGNATURE <b>John R. Roberts</b>			22c. DEGREE <b>M.D.</b>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. DATE SIGNED <b>5-27-86</b>	
22f. PHYSICIAN'S NAME (Type or print) <b>John R. Roberts</b>			22g. ADDRESS <b>Lech Raven UVA</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>6-2-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore Md.</b>		
24. FUNERAL DIRECTOR <b>Ann S. Matthews, Matthews Funeral Home</b> <b>3021 Eastern Ave., Baltimore, Md. 21224</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 2 1986</b>		25b. REGISTRAR'S SIGNATURE	

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W. H. H. H.

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W. H. H. H.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14031  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CORA PINKETT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5-9-86</b>			2b. HOUR <b>10:00</b> M				
3. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-2-1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO City</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LUTHERAN Hosp</b>				12a. USUAL OCCUPATION- (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS ZIP CODE <b>4601 PALL MALL RD 21215</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>LEWIS JONES</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FANNIE JONES</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-18-5170</b>		17. INFORMANT ADDRESS <b>NINA McCLAMY 3457 Childs Ct 21226</b>						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (if this hospital) attended the deceased from <b>02-21-86</b> 19 <b>86</b> , to <b>05-09</b> 19 <b>86</b> , that (we) last saw the deceased alive on <b>05-09</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Sissay Awuke MD</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SISSAY AWUKE</b>			22e. ADDRESS <b>Lutheran Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5/14/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Antebellum Cem PA</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Chesapeake 21226</b>			
24. FUNERAL DIRECTOR NAME <b>LOCKE FUNERAL HOME</b>			ADDRESS <b>1304 N. Gales Rd</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 13 1986</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL AFTER ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TURNOUT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14032

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR	
Chauncey K. Pirkey								5-22 19 86				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	Nov. 14 18		67 YRS.						5-22 19 86		9:42 a. M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U.S.A.				Baltimore City, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		3124 Guilford Avenue		Shipping Clerk		Bakery							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3124 Guilford Ave. 21218					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Herman Pirkey		Blanche Casidy											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		WW 11		220-10-4742		Keith Pirkey Balto., Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Seizure Disorder</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ethanolism</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? (head only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED							
Dennis F. Smyth, M.D.		Assistant				5-22-86							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
Dennis F. Smyth, M.D.		111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		5-27-86		Hillcrest		Cumberland Allegany Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Henry W. Jenkins & Sons Co., Balto., Md.				MAY 23 1986		John A. ...							

00-2115

London, Ontario Nov. 1, 1917

U.S.A.

Shipping Clerk, Bakery

3124 Guilford Ave., Baltimore, Md.

Baltimore, Md.

Mrs.

Cashier

John H.

Pinkey

Forman

220-10-4742 Keith Pinkey, Baltimore, Md.

Yes WW 11



Cum gratia, Baltimore, Md.

Hilliers

8-27-60

Encl.

Henry W. Jenkins & Sons Co., Baltimore, Md.



00-06546

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 0 3 3  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL PISTORIO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 13, 1986</b>			2b. HOUR M <b>AM</b>						
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 7, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Italy</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>						
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4201 Parkmont Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. - Clothing Manufacture</b>		12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4201 Parkmont Ave. 21206</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>August Pistorio</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary C. Cellura</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-03-0764</b>		17. INFORMANT ADDRESS <b>Mrs. Jennie Alberti Same as # 13e</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Obstructive Jaundice</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>with Liver Failure</b> (b) <b>with Liver Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>with Liver Failure</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hypothyroidism, congestive heart failure</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (If this hospital) attended the deceased from <b>JAN 1, 1986</b> , to <b>May 13, 1986</b> , that (we) last saw the deceased alive on <b>April 30, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Howard Bond</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/13/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Howard Bond, M.D.</b>						22e. ADDRESS <b>9618 Belair Rd.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5-16-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>						ADDRESS <b>Baltimore, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 14 1986</b>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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Leonard J. Egan, Inc. Baltimore, Md.

Special Agent in Charge, Baltimore, Maryland

James Bond, Ego.

May 15 1936

My Dear Mr. Egan:

I am sorry to hear that you are not well.

Very truly yours,

John

1001 Baltimore Ave. 21000

601 - 23000 Baltimore

Baltimore City

October 1, 1936

May 12, 1936



0016909

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMH - 16 60M 7/84  
(VA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be filed with the health department within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then place this certificate in the deceased's file. Page 4 should be filed with the health department. Page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial. **IMPORTANT:** If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				86 REG. NO. 14034					
1. DECEASED NAME (TYPE OR PRINT) <b>CECELIA PITTS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 15, 1986</b>				2b. HOUR <b>4:52 A</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 21 38</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>47</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Connor Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Bowman Connor</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>No</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>213-38-8286</b>		17. INFORMANT ADDRESS <b>Helen Stills + Hattie Jones 812 Shewell Ct. 21202</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>NONCARDIOGENIC PULMONARY EDEMA</b> 48 hrs. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sepsis</b> 24 hrs. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Alcohol abuse, neutropenia</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>May 13, 1986</b> to <b>May 15, 1986</b> , that (I) (we) last saw the deceased alive on <b>May 15, 1986</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)									
22b. SIGNATURE <b>Eric Brown</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>5/15/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eric Brown MD</b>				22e. ADDRESS <b>Johns Hopkins Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 19, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>William C. Brown 1206-08 W. North Ave. 21217</b>	
25a. DATE REC'D. BY REGISTRAR <b>MAY 19 1986</b>				25b. REGISTRAR'S SIGNATURE <b>Jana Davidson-Henderson</b>					

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000-06526

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

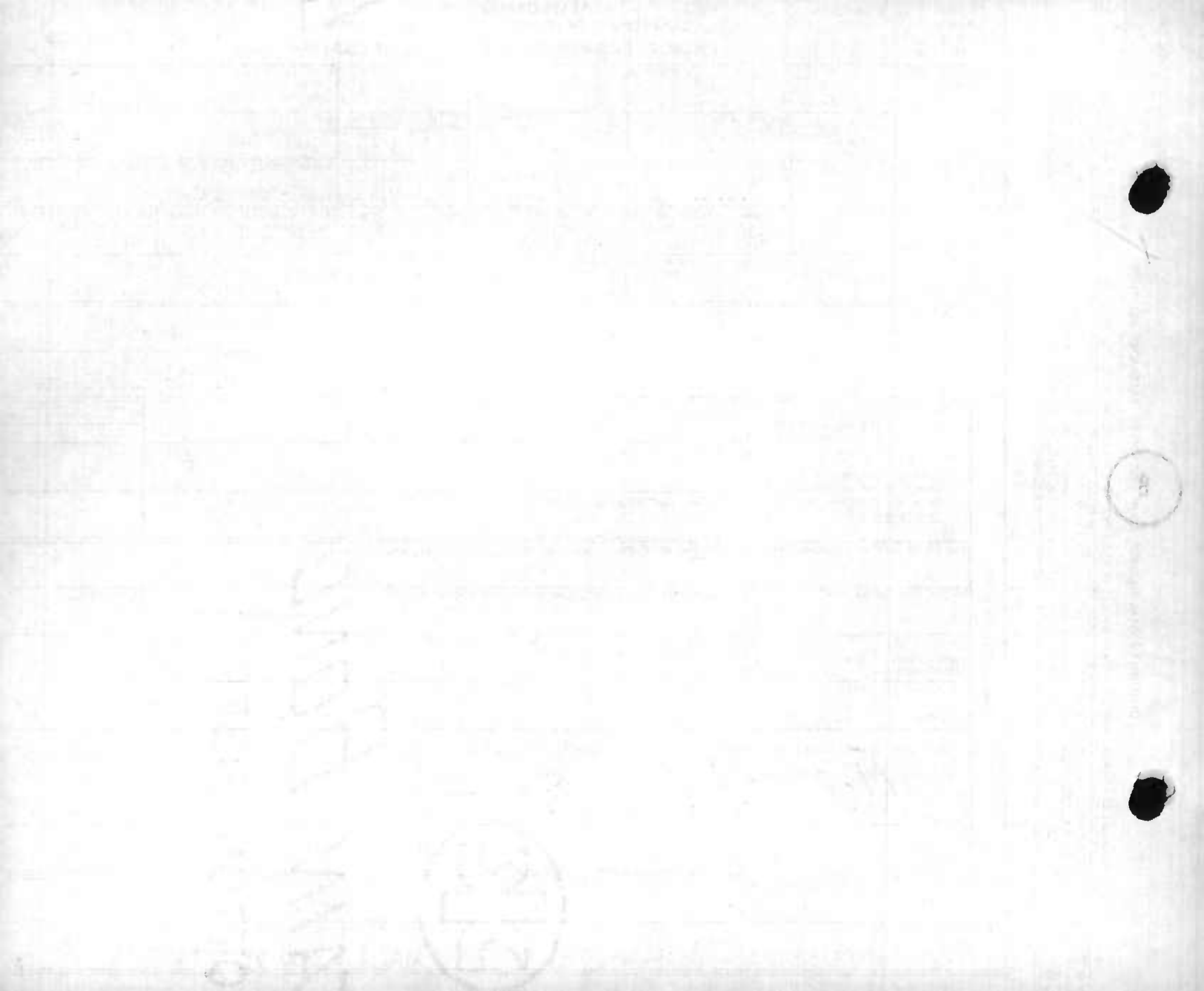
BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14035

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
STANTON		A.		PITTS			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	2d. HOUR
male	Black	1 26 50	36 YRS.			5 7 1986	4:28 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	U.S.A.				Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	University Hosp. (STU)			MEchanic		Auto	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Baltimore				1215 N. Stricker St. 21217	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
James A. Pitts		Sophia Harcum					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Unknown				Sophia L. Pitts 1215 N. Stricker Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stab wound of chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 3:32 M. 5-7- 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				Subject stabbed.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
		yard		1732 N. Calhoun St., Balto. City		MD	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 5-8-86	
EXAMINER'S NAME (TYPE OR PRINT)		Denni S. Smyth, M.D.		ADDRESS		111 Penn St., Balto., MD 21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL	5/15/86	Mount Zion Cemetery		Lansdowne, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
March Funeral Homes 1101 East North Avenue				MAY 14 1986		[Signature]	



00-07756

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND															
DEPARTMENT OF HEALTH AND MENTAL HYGIENE															
CERTIFICATE OF DEATH															
REG. NO. 86 14036															
1. FOR STATE REGISTRAR				2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)				FIRST				MIDDLE				LAST			
Lester				Pleasant											
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)			
Male				Black				Mar. 4. 1907				79 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland				USA								Baltimore City MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				Francis Scott Key				Custodian				Retired			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Maryland				Baltimore								2706 Lodge Farm Rd. 21219			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
Ernest				Pleasant				Anna							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
No				216-28-8188				Emmer M. Pleasant				2706 Lodge Farm Rd. 21219			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Respiratory Arrest															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) Large Cerebral Vascular Accident															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
Metastatic Prostate Cancer															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/24, 1986, to 5/24, 1986, that (I) (we) lost saw the deceased alive on 5/24, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED			
Steven												5/24/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
Steven				R. Machlin				Francis Scott Key Hospital				Balt., Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				5-29-86				Arbutus Memorial Pk.				Arbutus, Balto. Co., Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Marshall W. Jones, Jr. FH				21229 4101 Edmondson Ave.				MAY 27 1986				John Davidson-Hendell			

BP.

DHMH-16 30M 2/80  
(VRA 15, 4)

Male

White

Mar. 4, 1901

Married

White

Baltimore City

Married

Catholic

Married

Married

Married

Married

Mar. 4, 1901

Married

Married

Married

Married

Married



00-06695

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

14037

1. DECEASED NAME (TYPE OR PRINT) Charles Pletka			2a. DATE OF DEATH MONTH DAY YEAR 5 14 86			2b. HOUR 1:15AM				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 15, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 yrs. YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mattress Worker		12b. KIND OF BUSINESS OR INDUSTRY Foster Bro		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3327 Elmley Avenue 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-03-1325		17. INFORMANT ADDRESS Marie Pletka same address as above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe respiratory failure</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>① COPD</u> <u>② Severe Kyphosis</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>May 5</u> , 19 <u>86</u> , to <u>May 13</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>May 13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Scott Rifkin</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5/14/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SCOTT RIFKIN</u>						22e. ADDRESS Union Memorial Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-17-86		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.			
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213						25a. DATE REC'D. BY REGISTRAR MAY 15 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>		

BP  
DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates 1 and 2, should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this medical examiner must be notified before the body is released.

MEDICAL CERTIFICATION

WAD  
C

100-100

100-100



WAD  
C



00-07724

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 0 3 8  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anita Jayne Polk			2a. DATE OF DEATH MONTH DAY YEAR May 25, 1986		2b. HOUR 5:00 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 07 01 02		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa St. Michael		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Alfred A. Morris		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Belle Mundy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A		16b. SOCIAL SECURITY NO. 217-01-4324		17. INFORMANT ADDRESS Mrs. Joan P. Barroll Same as # 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myeloproliferative disorder</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>severe hepatosplenomegaly</i>		
--	--	--

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>2/12</i> 19 <i>86</i> , to <i>5/25</i> 19 <i>86</i> , that (I) <input checked="" type="radio"/> lost saw the deceased alive on <i>5/20</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="radio"/> (did) (did not) view the body after death.					
22b. SIGNATURE <i>Harold B. Bob</i> DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED May 25, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold B. Bob, M.D.			22e. ADDRESS 7220 Park Heights Ave. Balto., MD		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 05/25/86	23c. NAME OF CEMETERY OR CREMATORY Security Process	23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore, MD
24. FUNERAL DIRECTOR NAME Cremation Society of MD		25. DATE RECEIVED BY REGISTRAR MAY 27 1986	

11/11/11

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00-08346

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 14039  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CHRIS C. POLLARD			2a. DATE OF DEATH MONTH DAY YEAR 5 28 86			2b. HOUR 1145 P.M.	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 1 28 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CTY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
12b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		13a. STATE MD		13b. CITY OR TOWN BALTIMORE		13c. STREET ADDRESS / ZIP CODE 4001 ELDORADO AVE 21215	
14. FATHER'S NAME Walker		15. MOTHER'S MAIDEN NAME Daisy Jones		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-18-1284	
17. INFORMANT Sarah F. Pollard		ADDRESS 4001 Eldorado Ave					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASYSTOLE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 MIN.	
DUE TO, OR AS A CONSEQUENCE OF (b) METABOLIC ACIDOSIS				4 1/2 hours	
DUE TO, OR AS A CONSEQUENCE OF (c) HYPOPERFUSION, VOLUME DEPLETION				6 1/2 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): LYMPHOMA, VIRAL HEPATITIS, HEPATIC ENCEPHALOPATHY, GI BLEED					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/28, 19 86, to 5/28, 19 86, that (I) (we) last saw the deceased alive on 5/28, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE David Lee, M.D.		DEGREE		22c. DATE SIGNED 5/28/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID LEE		22e. ADDRESS Sinai Hosp, Belvedere & Greenspring			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/2/86		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore CO MD					
24. FUNERAL DIRECTOR March Funeral Home West 4300 Wash Avenue				25a. DATE REC'D. BY REGISTRAR JUN 3 1986	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



00-06553

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and fill in by the funeral director, page 3. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 1 4 0 4 0

1. DECEASED NAME (TYPE OR PRINT) <b>Violet Louise</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 10 1986</b>		2b. HOUR <b>6:09 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 5 1986</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>None</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS, 4-ZIP CODE <b>4940 Eastern Ave. 21224</b>	
14. FATHER'S NAME <b>Dalbert P. Costello</b>		15. MOTHER'S MAIDEN NAME <b>Joy Ann Popkins</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Joy Ann Popkins</b>		ADDRESS <b>312 E. 12th Ave. Hanover, W.Va. 25438</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>heuristic enterocolitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>hypeline membrane disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>1 d</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>hypeline membrane disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>5/10</b> 19 <b>86</b> , to <b>5/10</b> 19 <b>86</b> , that (1) (we) lost saw the deceased alive on <b>5/10</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Mark L. Hudak MD</b>		DEGREE		22c. DATE SIGNED <b>5-11-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARK L. HUDAK MD</b>		22e. ADDRESS <b>18 LACOSTA COURT, TOWSON MD 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-13-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bunker Hill Cemetery</b>	
				23d. LOCATION <b>Bunker Hill Berkeley W.Va.</b>	
24. FUNERAL DIRECTOR NAME <b>Douglas R. Snowden</b>		25. DATE RECEIVED BY REGISTRAR <b>MAY 14 1986</b>		26. REGISTRAR'S NAME <b>Jule Barker-Rodriguez</b>	



00-05748

1- STATE REGISTRAR FilmG616

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 14041  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alexander S. Porter</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5 5 86</i>			2b. HOUR <i>710<sup>M</sup></i>			
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 21 1927</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>59</i>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>YRS</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Francis Scott Key</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Soc. Sec.</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>811 Bradhurst Rd. 21212</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Alexander S. Porter</i>				15. MOTHER'S MAIDEN NAME MIDDLE LAST <i>Eva M. Morgan</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WWII</i>		17. INFORMANT <i>Deborah C. Daniel</i>		ADDRESS <i>811 Bradhurst Rd. 21212</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Pulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Dehydration</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Respiratory</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>5/5/86</i> , 19__, to <i>5/5/86</i> , 19__, that (I) (we) lost saw the deceased alive on <i>5/5/86</i> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>W. C. Masser</i>						DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. A. Masser</i>						22e. ADDRESS <i>FSH Hosp</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>5/7/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Dulaney Valley</i>		23d. LOCATION <i>Cockeysville Balto. Md.</i>		
24. FUNERAL DIRECTOR NAME <i>Mitchell-Wiedefeld</i>						ADDRESS <i>6500 York Rd.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 6 1986</i>	
						25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



POST OFFICE

0-07097

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 14042  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Audrey Anna Potce</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5/19/86</b>		2b. HOUR MIN. <b>11:27 A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 12 19</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>66</b>		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Leroy Henkel</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Myers</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216098135</b>		17. INFORMANT <b>Joseph W. Potce</b>		ADDRESS <b>Same as #13</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive Heart Failure</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>7 hr.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>5-18, 19-86</b> to <b>5-18, 19-86</b> , that (I) (we) last saw the deceased alive on <b>5-18, 19-86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) not view the body after death.								
22b. SIGNATURE <b>Mitchell Jelen</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5-18-86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mitchell Jelen</b>		22e. ADDRESS <b>3001 S. Henshaw St. Pkts, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-22-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto A.A. MD</b>		
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Homes</b>		24b. ADDRESS <b>237 E. Patapsco Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 20 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. Page 4 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.



AD-1A



AD-1A



200



00-06642

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

14043

1. DECEASED NAME (TYPE OR PRINT) <b>Laurie Beth POWELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5 11 86</b>			2b. HOUR <b>4:20 AM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 11 86</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>infant</b>			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of MD Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Worcester</b>		13c. CITY OR TOWN <b>Ocean City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES EDWARD POWELL</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CHRISTY MC GRATH</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>Mayor Roland Powell, 12th &amp; St. Louis Ave., O.C., MD 21842</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>IMMATURITY (23 weeks gestation)</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>5-11-86</b> to <b>5-11-86</b> , that (I) (we) lost saw the deceased alive on <b>5-11-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Isabelita G. Frattarolo</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Isabelita G. Frattarolo</b>			22e. ADDRESS <b>UNIV. OF MARYLAND HOSPITAL BALTIMORE, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5/15/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Berlin Worcester MD</b>		
24. FUNERAL DIRECTOR NAME <b>W. Kirk Burbage,</b>			108 Williams St. <b>Berlin, MD 21811</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 15 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial/transfer permit. Then please remove carbon pages 1, 2, and 3 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP



00-06641

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 0 4 4  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) <b>Leslie Ann POWELL</b>		MONTH DAY YEAR <b>5 11 86</b>		7:15 A.M.	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 11 86</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>infant</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIV. OF MARYLAND HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Worcester</b>	13c. CITY OR TOWN <b>Ocean City</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt. 1, Box 317A/21842</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES EDWARD POWELL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CHRISTY MCGRATH</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mayor Roland Powell, 12th &amp; St. Louis Ave., O.C., MD 21842</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>IMMATURITY (23 weeks gestation)</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>5-11</b> , 19 <b>86</b> , to <b>5-11</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>5-11</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Isabella G. Frattarola</b>		DEGREE		22c. DATE SIGNED <b>5-11-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Isabella G. Frattarola</b>		22e. ADDRESS <b>UNIV. OF MARYLAND HOSPITAL BALTIMORE, MD</b>		22f. DATE RECD. BY REGISTRAR REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>5/15/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Berlin Worcester MD</b>	
24. FUNERAL DIRECTOR NAME <b>W. Kirk Burbage, 108 Williams St. Berlin, MD 21811</b>					

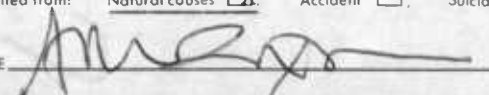





00-05976

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. 1 4 0 4 5

1. DECEASED NAME (TYPE OR PRINT)			FIRST JEROME			MIDDLE PRATT			LAST			2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 5 2 1986			2b. HOUR M		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 06-03-1928		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 5 2 1986		2d. HOUR P.M. 2:01					
2a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1559 Woodyear St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland				13b. CITY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1559 N. Woodyear Street							
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Pratt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jacobs													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT Mary Pratt				ADDRESS 1559 N. Woodyear St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 5-3-86					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 05-07-86		23c. NAME OF CEMETERY OR CREMATORY Garrison Forset Va. Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland							
24. FUNERAL DIRECTOR NAME Brown/Thompson F.H.				ADDRESS 1913 W. Baltimore St.				25a. DATE REG'D. BY REGISTRAR MAY 8 1986				25b. REGISTRAR'S SIGNATURE 					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY. IF NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE  
FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED  
WITHIN 72 HOURS. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

DAVID B. WINKELHOF

2000 OCTOBER 2002



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8614046  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOUR MIN.	
CLIFFORD L PRESTON SR.		04 26 86		06 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	Caus.	MONTH DAY YEAR	63 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
USA Md.	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
BART.	UNIV OF MARYLAND HOSP.		Retired	Hwy. Main.	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS ZIP CODE	
MD	Cecil	North East	Box 41 North East	Charles Dr. 21911	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
WALTER R PRESTON		Wilehemina Jones			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
YES		215-14-0596		440 Ches. Dr. Frances Preston Charlestown, Md. 21911	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SEPSIS</u>					4/26/86
(c) <u>LEUKEMIA - ACUTE</u>					4/25/86
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					3/18/86
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/26</u> 19 <u>86</u> saw the deceased alive on <u>4/26</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		<u>4/25</u> 19 <u>86</u> to <u>4/26</u> 19 <u>86</u>			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
H. A. OKEN		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
H. A. OKEN MD		UNIV OF MARYLAND HOP CANCER CENTER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	4-29-86	North East Meth.	North East Cecil Md. STATE		
24. FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Tough Funeral Home North East, Md.		APR 29 1986		Julia Davidson-Randall	

2025 COL. CH. 1950

CHIEF IN BIRD

00-06522

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 0 4 7

1. DECEASED NAME (TYPE OR PRINT) <b>ERNESTINE PRICE</b>			2a. DATE OF DEATH MONTH <b>5</b> DAY <b>9</b> YEAR <b>86</b>			2b. HOUR <b>12:45 AM</b>							
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>04</b> DAY <b>07</b> YEAR <b>61</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>25</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALT. MD</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALT. MD</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>MD</b>			13b. COUNTY <b>BALT.</b>		13c. CITY OR TOWN <b>BALT</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>905 BARRETT ST 21230</b>				
14. FATHER'S NAME FIRST <b>BENNIE</b> MIDDLE <b>PRICE</b> LAST <b>PRICE</b>			15. MOTHER'S MAIDEN NAME FIRST <b>LOUISE</b> MIDDLE <b>PRICE</b> LAST <b>PRICE</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>213-72-7602</b>			17. INFORMANT ADDRESS <b>LOUISE PRICE S/A (MOTHER)</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROBABLY LUPUS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>5/9</b> <b>1986</b> to <b>5/9</b> <b>1986</b> , that (I) (we) lost saw the deceased alive on <b>5/9</b> <b>1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>David A. Flick</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>5/9/86</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Flick, David A.</b>						22e. ADDRESS <b>22 SOUTH GREENE STREET</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>05-14-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Baltimore, Maryland</b> COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>Brown/Thompson F.H.</b> ADDRESS <b>1913 W. Baltimore Street</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 14 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Jana H. H. H. H. H.</b>					

MEDICAL CERTIFICATION

99

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial/cremation/removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



0-07795

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. STATE REGISTRAR					8 6 1 4 0 4 8				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
Clara Frances Proctor					May 20, 1986				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		White		12/31/19		66 YRS.		1643	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
West Virginia		USA				Baltimore City		Baltimore	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE	
St. Agnes Hospital				Retired maid		xxx motel		111 Gorman Ave. 20701	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MD		Prince Geo.		Laurel				111 Gorman Ave. 20701	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Joseph Wiseman		Jessie unknown		no		227428529		Robert J. Stanton same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE									3 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b) PERICARDIAL THROMBOSIS									3 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c) RHEUM RHEUMATOID ARTHRITIS									20 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: DEMETIA OF ALZHEIMER'S TYPE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 5-31, 1985, to 5-20, 1986, that (2) I saw the deceased alive on 5-20, 1986, and that in my (aur) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Christine L. Comerford						5-20-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
CHRISTINE L. COMERFORD, MD		544 OLD FREDERICK RD #10 BALTIMORE, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		May 23, 1986		Westview Memorial Park		Catonsville, Md			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Donaldson Funeral home, Laurel, Md				MAY 26 1986		John Davidson-Randall			



0-05702

Page

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1



Page 1 of 1

00-06234

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Film G615 item 16b

FOR STATE REGISTRAR  
5/19/86 rjaSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 0 4 9

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAWRENCE ANTHONY PROCTOR			2a DATE OF DEATH MONTH DAY YEAR 5-8-86			2b HOUR 2:00 AM		
3 SEX male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 20 85			6 AGE (IN YEARS LAST BIRTHDAY) 13 mths.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b KIND OF BUSINESS OR INDUSTRY N/A	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b CITY OR TOWN Maryland N/A Baltimore				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4934 Denmore Ave 21215		
14 FATHER'S NAME FIRST MIDDLE LAST Kenneth A. Keene				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tammy D. Proctor				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17 INFORMANT ADDRESS Agnes Proctor 4934 Denmore Ave. 21215				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>shock pneumococcal meningitis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <u>5-7-86</u> , 19____, to <u>5-8-86</u> , 19____, that (I) (we) last saw the deceased alive on <u>5-8-86</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE J. McDaniel M.D.				DEGREE M.D.				22c. DATE SIGNED 5-8-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEANETTE McDaniel M.D.				22e ADDRESS 22. S. Green Street 5104 Baltimore MD				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 5/13/86		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24 FUNERAL DIRECTOR NAME Leroy O. Dyett & Son 4600 Lib.Hghts.Ave.				25a DATE OF DEATH MAY 12 1986		25b REGISTRAR'S SIGNATURE John L. Anderson		

BP \_\_\_\_\_

08-10334

20% Carbon Fiber

100%

100%



MAY 12 2008

00-08238

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 0 5 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Tista		FIRST MIDDLE LAST Queen baby Girl		2a. DATE OF DEATH MONTH DAY YEAR 5 6 86		2b. HOUR 11:19 AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 16 86		6. AGE (IN YEARS LAST BIRTHDAY) 20 days	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Baltimore		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 21207 2023 Beechwood Av, Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST ERWIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST michele Queen		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS							

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Perinatal Asphyxia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) prolapsed umbilical Cord

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-16, 19 86, to 5-6, 19 86, that (I) (we) lost saw the deceased alive on 5/6, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Monther Sharif		DEGREE (Resident)		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/6/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Monther Sharif		22e. ADDRESS 900 CATON AVENUE BALTIMORE MD 21229					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/16/86		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Fun'l Home, 4107 Wilkens Ave.				25a. DATE REC'D. BY REGISTRAR JUN 2 1986		25b. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

BALTIMORE CITY

ST. JOSEPH HOSPITAL

BALTIMORE



200 SOUTH AVENUE BALTIMORE MD 21201

00-05788

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

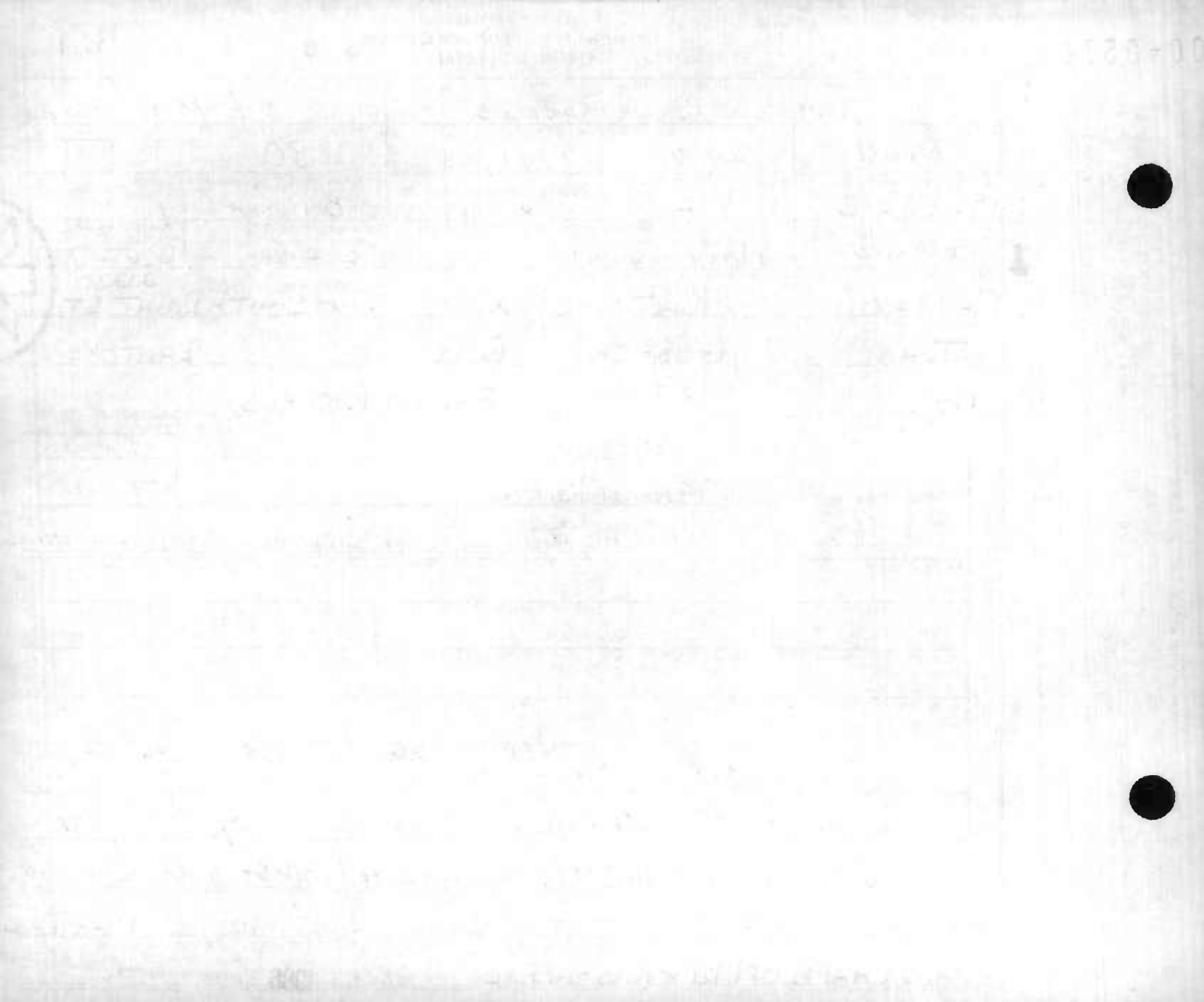
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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bertha P. Radecke			2a. DATE OF DEATH MONTH DAY YEAR 5/5/86		2b. HOUR 7:55 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7/1/05		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CASHIER		12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOHN GOSPER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose LANTO		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-01-3014		17. INFORMANT ADDRESS Family Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic carcinoma of uncertain primary, Likely cervical/uterine					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~1 month ~1 month
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (he) (this hospital) attended the deceased from 4/10, 19 86, to 5/5, 19 86, that (we) last saw the deceased alive on 5/5, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.					
22b. SIGNATURE Joanna D. Brandt M.D.				22c. DATE SIGNED 5/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joanna D. Brandt, M.D.				22e. ADDRESS Mercy Hospital, 301 St. Paul St. Baltimore, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 7, 1986		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS	
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES		ADDRESS 8800 ROAD HARFORD		25a. DATE REC'D. BY REGISTRAR MAY 6, 1986	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez	

MEDICAL CERTIFICATION





00-07057

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8614052

1 - FOR  
STATE  
REGISTRAR

Anna Mae Reilly

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna MAE Reilly			2a. DATE OF DEATH MONTH DAY YEAR 5 19 86		2b. HOUR 7 <sup>52</sup> a.m.	
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 6 1931		
6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		
12b. KIND OF BUSINESS OR INDUSTRY Hospital						

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Essex	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 331 Southeastern Terrace 21221			

14. FATHER'S NAME FIRST MIDDLE LAST Russell Watkins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Youngblood		
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS James J. Reilly, Jr. 7231 River Drive Balto., Md. 21219	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Liver failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>renal failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 5/5 19 86, to 5/19 19 86, that (I) (we) last saw the deceased alive on 5/19 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Lea Stern MD		DEGREE		22c. DATE SIGNED 5/19/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEA STERN		22e. ADDRESS 4940 Eastern Ave Baltimore MD			

23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE 5/21/86		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d. LOCATION Baltimore Md COUNTY STATE	
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24. FUNERAL DIRECTOR Bruzdzinski Funeral Home PA 1407 Old Eastern Ave		25a. DATE REC'D. BY REGISTRAR MAY 20 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodell	
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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove to the Registrar. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

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00-07218

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 0 5 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Kathleen H. Raitt</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5 17 86</b>		2b. HOUR <b>11<sup>00</sup> a.m.</b>						
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 2 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>57</b>		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>873 Jaydee Avenue 21222</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Marion Ewing</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Viola Not Known</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-22-9154</b>			17. INFORMANT ADDRESS <b>William C. Raitt, Jr. Same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/16/86</b> 19 <b>86</b> to <b>5/17</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>5/17/86</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Lea Stern M.D.</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>5/17/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEA STERN</b>						22e. ADDRESS <b>4940 Eastern Ave Baltimore MD 21224</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5/20/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>White Marsh Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 21 1986</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		
7922 Wise Avenue			Dundalk, Maryland			21222					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies, signs and 2 should be filed within 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 includes any injury, or other traumatic experience, the death certificate must be notified to the

BP

81550-00

2025 COLLECTION

8

00-08636

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 0 5 4

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rose Marie Raivel			2a. DATE OF DEATH MONTH DAY YEAR 5 24 86			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 19 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 433 N. Clinton St. 21224				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired/Schoennemann/Martin		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Loukota				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Kandlik					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-01-2920A		17. INFORMANT ADDRESS Mr. William Raivel 433 N. Clinton St. 21224					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Widely metastatic colon carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>January</u> , 19 <u>84</u> , to <u>May 24</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>March</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Gregory M. Hall</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>5/27/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory M. Hall, M. D. (323-5577)				22e. ADDRESS 1900 E. Northern Parkway Suite 105					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-28-86		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home				24b. ADDRESS 7401 Belair Rd. BALTO. MD. 21236		25a. DATE REC'D. BY REGISTRAR NO 2 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Rodriguez	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DATE TIME PLACE

1950 10 10 10:00 AM

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00-07095

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 0 5 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ORLON A. RALLS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>05-19-86</b>		2b. HOUR <b>5:50 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 9 22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital, Balto. Md.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Pressman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Alfreds</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1640 S. Charles St. Balto. Md. 21230</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>amuel A. Ralls</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Myra M. Curry</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. 2</b>	17. INFORMANT ADDRESS <b>Mrs. Dorothy S. Ralls, Same as above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gram NEGATIVE Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gram NEGATIVE PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 day</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Metastatic Adenocarcinoma</b>					
19a. DATE OF OPERATION <b>none</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5/18</b> , 19 <b>86</b> , to <b>5/19</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>5/19</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Robert C. Greenwell Jr. MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>5/19/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT C. Greenwell Jr MD</b>		22e. ADDRESS <b>Mercy Hospital BALTIMORE, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>5/22/1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Elkridge. Howard Co. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 20 1986</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.



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1/10/21

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00-08209

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8614056

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CAROLINE RUTH RAMIREZ			2a. DATE OF DEATH MONTH DAY YEAR MAY 29, 1986		2b. HOUR P 10:25 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 22, 1944		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	12b. KIND OF BUSINESS OR INDUSTRY High School	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Howard	13c. CITY OR TOWN Mt. Airy	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Kenneth M. Hayes			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fay Brintle		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-42-5058		17. INFORMANT ADDRESS David K. Hayes, Baltimore, Md. 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC BREAST CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>NONE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>NONE</u> Approximate interval between onset and death: <u>6 years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>NONE</u>					
19a. DATE OF OPERATION <u>N/A</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>		21b. TIME OF INJURY HOUR A.M. MONTH DAY P.M. <u>N/A</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>N/A</u>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <u>N/A</u>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>N/A</u>	
22a. I certify that (if this hospital) attended the deceased from <u>5/21</u> , 19 <u>86</u> , to <u>5/29</u> , 19 <u>86</u> , that (I, we) last saw the deceased alive on <u>5/29/86</u> , 19 <u>86</u> , and that (my, our) opinion death occurred on the date and hour and from the causes stated above. (I, we) did not view the body after death.					
22b. SIGNATURE <u>IC Kall</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>5/29/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>STUART KATZ</u>		22e. ADDRESS <u>4940 Eastern Ave 21224</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>June 2, 1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Friends</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>White Plains, N.C.</u>		24. FUNERAL DIRECTOR <u>Olin L. Molesworth, P.A., ADD, Damascus, Md.</u>			
25a. DATE REC'D. BY REGISTRAR <u>JUN 2 1986</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRINCE STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use of the burial/transport permit. Then please remove this certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

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John L. Johnson, Jr., President, 1941-1942

00-06103

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8614057  
REG. NO.1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DELLA RANDALL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5-6-85</b>		2b. HOUR <b>2130 PM</b>		
3. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01-20-03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE Co. Gen. Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>7013 BARRINGTON Rd. 21207</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM LEWIS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY GILES</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
16b. SOCIAL SECURITY NO.		17. INFORMANT <b>CHART</b>		17. ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC RENAL FAILURE.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC PYELONEPHRITIS</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>GASTRO INTESTINAL BLEEDING -</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		22a. I certify that (I) (this hospital) attended the deceased from <b>4-22-85</b> to <b>5-6-85</b> , that (I) (we) last saw the deceased alive on <b>5-6-85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22b. SIGNATURE <b>R. DEPESTRE</b> MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22c. DATE SIGNED <b>5-6-85</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. DEPESTRE</b>		22e. ADDRESS <b>BALTIMORE COUNTY GENERAL HOSP.</b>		23a. BURIAL, CREMATION, REMOVAL (CHECK IF Y) <b>Burial</b>	
23b. DATE <b>5-10-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CRESTLAWN MEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>		24. FUNERAL DIRECTOR NAME <b>E.L. Phillips</b> ADDRESS <b>1721 N. MONTGOMERY ST.</b>	
25a. DATE REC'D. BY REGISTRAR <b>MAY 9 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. DATE REC'D. BY REGISTRAR <b>MAY 9 1986</b>		25d. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

2. MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **CARDIORESPIRATORY ARREST.**  
DUE TO, OR AS A CONSEQUENCE OF (b) **CHRONIC RENAL FAILURE.**  
DUE TO, OR AS A CONSEQUENCE OF (c) **CHRONIC PYELONEPHRITIS**  
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a **GASTRO INTESTINAL BLEEDING -**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?  
YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
**P.M. 19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **4-22-85** to **5-6-85**, that (I) (we) last saw the deceased alive on **5-6-85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE  
**R. DEPESTRE** MD  
DEGREE  
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED  
**5-6-85**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
**R. DEPESTRE**

22e. ADDRESS  
**BALTIMORE COUNTY GENERAL HOSP.**

23a. BURIAL, CREMATION, REMOVAL  
(CHECK IF Y)  
**Burial**

23b. DATE  
**5-10-86**

23c. NAME OF CEMETERY OR CREMATORY  
**CRESTLAWN MEM.**

23d. LOCATION  
CITY OR TOWN COUNTY STATE  
**BALTIMORE MD.**

24. FUNERAL DIRECTOR  
NAME  
**E.L. Phillips** ADDRESS  
**1721 N. MONTGOMERY ST.**

25a. DATE REC'D. BY REGISTRAR  
**MAY 9 1986**

25b. REGISTRAR'S SIGNATURE  
**[Signature]**

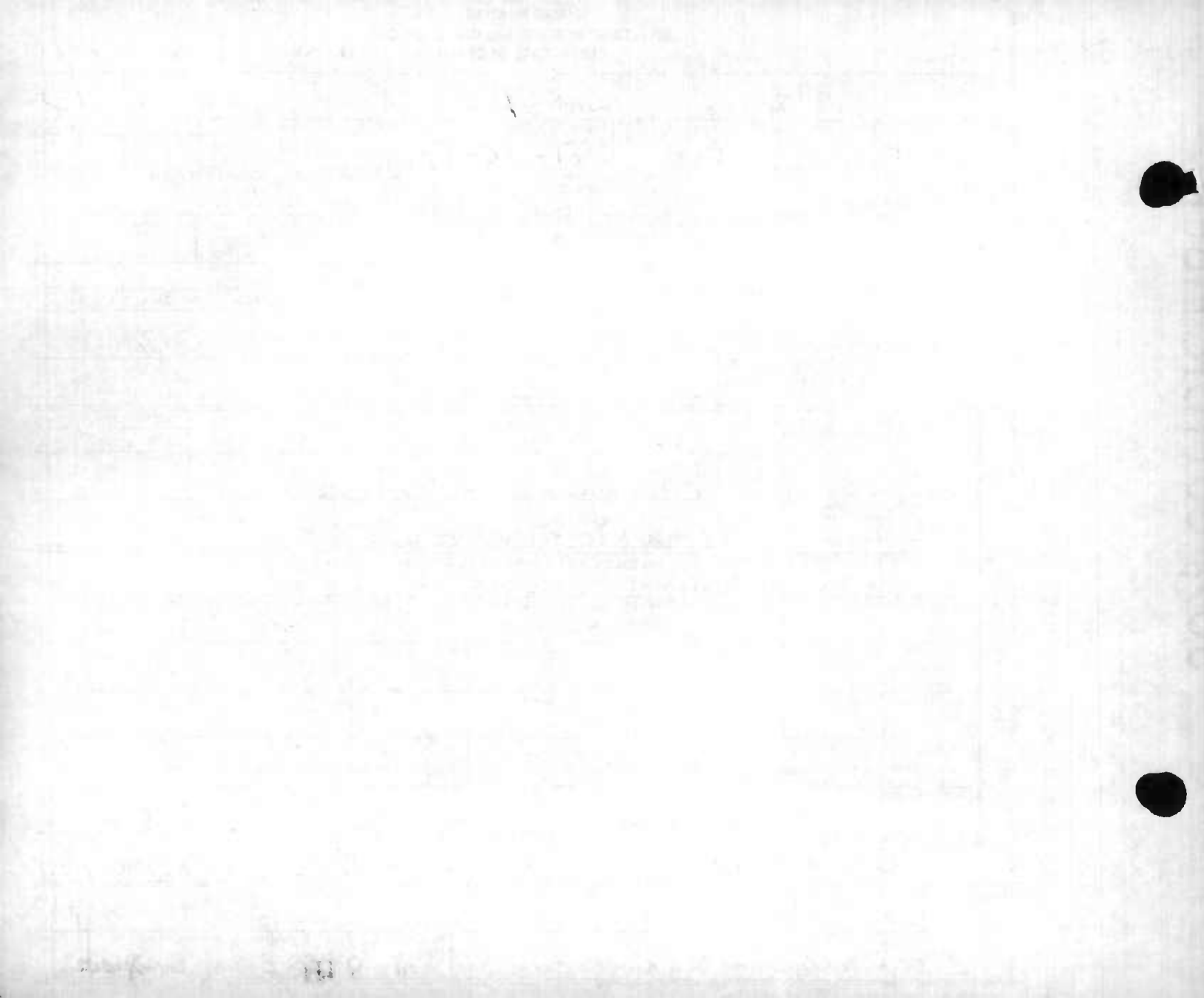
25c. DATE REC'D. BY REGISTRAR  
**MAY 9 1986**

25d. REGISTRAR'S SIGNATURE  
**[Signature]**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate must be filed with this certificate.



00-05958

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 0 5 8  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CARL HENRY RAPP</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 5, 1986</b>		2b. HOUR <b>11:10<sup>P</sup><sub>M</sub></b>
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 11 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MACHINIST</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>KOPPERS CO.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY RAPP</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CARRIE BROWN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 218-05-4510</b>		17. INFORMANT ADDRESS <b>NELLIE RAPP (WIFE) SAME ADDRESS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>4-15</u> , 19 <u>86</u> , to <u>5-5</u> , 19 <u>86</u> , that (I) (we) saw the deceased alive on <u>4-15</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Marion C. Kowalewski</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>5-8-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Marion Kowalewski</b>		22e. ADDRESS <b>8600 Harford Rd.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>5/8/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME <b>SCHIMUNEK FUNERAL HOME, INC.</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 8 1986</b>		
24. FUNERAL DIRECTOR ADDRESS <b>3331 Brehms Lane Balto. Md. 21213</b>			25b. REGISTRAR'S SIGNATURE <u>John Davidson Henderson</u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the signature of the attending physician. The low requires that the death certificate be executed with the signature of the attending physician and a complete statement of the cause of death. Pages 1 and 2 should be filed with the death certificate. Pages 3 and 4 should be filed with the death certificate. Pages 5 and 6 should be filed with the death certificate. Pages 7 and 8 should be filed with the death certificate. Pages 9 and 10 should be filed with the death certificate. Pages 11 and 12 should be filed with the death certificate. Pages 13 and 14 should be filed with the death certificate. Pages 15 and 16 should be filed with the death certificate. Pages 17 and 18 should be filed with the death certificate. Pages 19 and 20 should be filed with the death certificate. Pages 21 and 22 should be filed with the death certificate. Pages 23 and 24 should be filed with the death certificate. Pages 25 and 26 should be filed with the death certificate. Pages 27 and 28 should be filed with the death certificate. Pages 29 and 30 should be filed with the death certificate. Pages 31 and 32 should be filed with the death certificate. Pages 33 and 34 should be filed with the death certificate. Pages 35 and 36 should be filed with the death certificate. Pages 37 and 38 should be filed with the death certificate. Pages 39 and 40 should be filed with the death certificate. Pages 41 and 42 should be filed with the death certificate. Pages 43 and 44 should be filed with the death certificate. Pages 45 and 46 should be filed with the death certificate. Pages 47 and 48 should be filed with the death certificate. Pages 49 and 50 should be filed with the death certificate. Pages 51 and 52 should be filed with the death certificate. Pages 53 and 54 should be filed with the death certificate. Pages 55 and 56 should be filed with the death certificate. Pages 57 and 58 should be filed with the death certificate. Pages 59 and 60 should be filed with the death certificate. Pages 61 and 62 should be filed with the death certificate. Pages 63 and 64 should be filed with the death certificate. Pages 65 and 66 should be filed with the death certificate. Pages 67 and 68 should be filed with the death certificate. Pages 69 and 70 should be filed with the death certificate. Pages 71 and 72 should be filed with the death certificate. Pages 73 and 74 should be filed with the death certificate. Pages 75 and 76 should be filed with the death certificate. Pages 77 and 78 should be filed with the death certificate. Pages 79 and 80 should be filed with the death certificate. Pages 81 and 82 should be filed with the death certificate. Pages 83 and 84 should be filed with the death certificate. Pages 85 and 86 should be filed with the death certificate. Pages 87 and 88 should be filed with the death certificate. Pages 89 and 90 should be filed with the death certificate. Pages 91 and 92 should be filed with the death certificate. Pages 93 and 94 should be filed with the death certificate. Pages 95 and 96 should be filed with the death certificate. Pages 97 and 98 should be filed with the death certificate. Pages 99 and 100 should be filed with the death certificate.

BP





0-05949

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

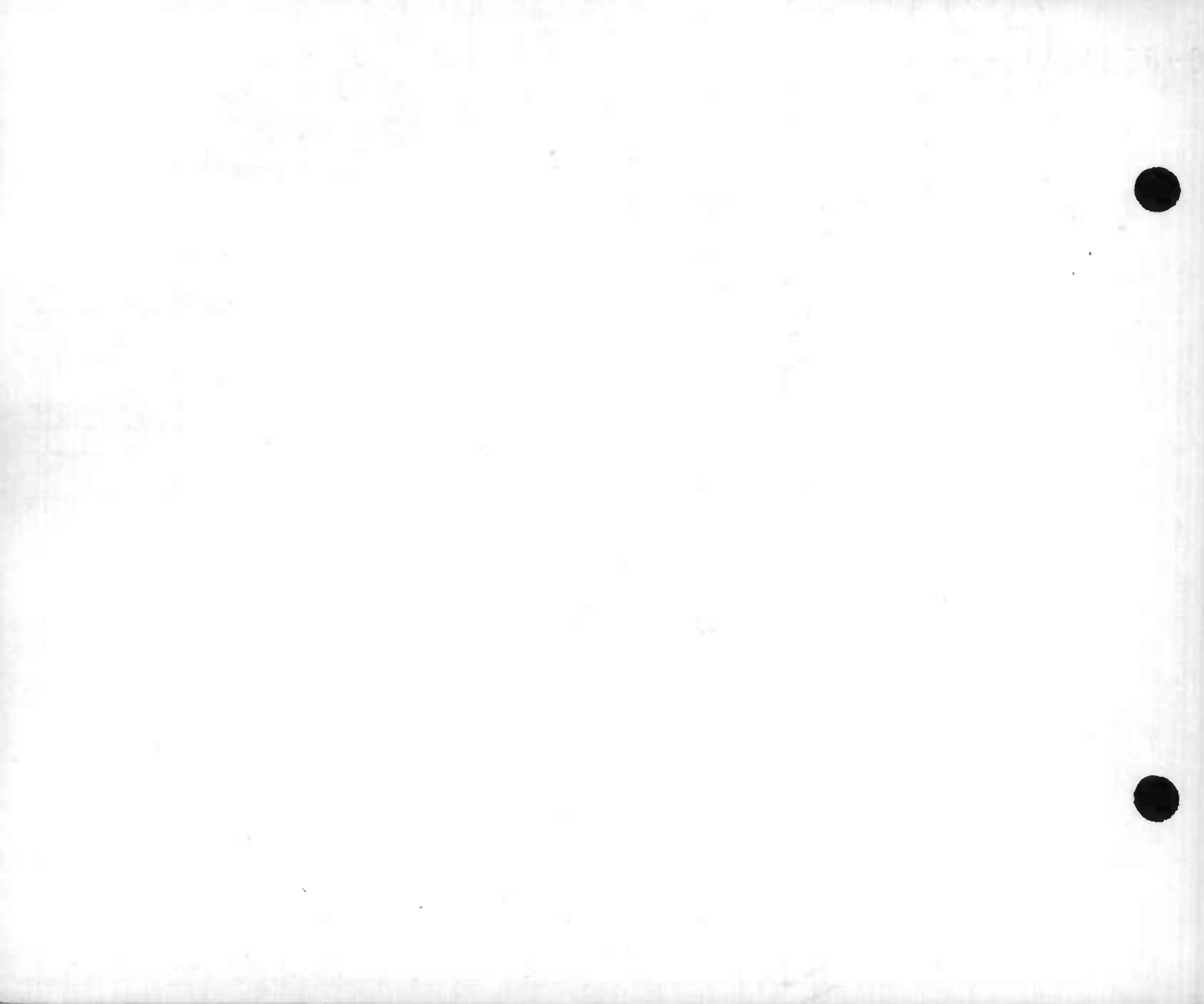
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8614059  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Henry A. Rawlings</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5/5/86</b>		2b. HOUR <b>2:03 AM</b>			
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9-2-13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>America</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WYMAN Park Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK AND INDUSTRY OR WORKING LIFE) <b>LETTER CARRIER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. POSTAL SERVICE</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>LAWRENCE RAWLINGS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FANNIE GREEN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT <b>BEATRICE T. RAWLINGS</b> ADDRESS <b>3544 Lynchester Road 212-15</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac Arrest vs. Septic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Infection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Injury</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Renal Failure</b>								
19a. DATE OF OPERATION <b>4/29/86</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Atherosclerosis, Gangrene of Left leg</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>5/1/86</b> to <b>5/5/86</b> that (I) (we) last saw the deceased alive on <b>5/5/86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE <b>Robert L. Murray, Jr.</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>5/5/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert L. Murray, Jr.</b>		22e. ADDRESS <b>31 East 31st Street, Balt. Md. 21218</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5/8/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MD. NATIONAL MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LAUREL, MARYLAND</b>		
24. FUNERAL RECORDS NAME ADDRESS <b>Sons Funeral Home, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 8 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Lelia Barker</b>		

BP



00-06013

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. RETAIN PAGE 4 FOR YOUR FILES. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

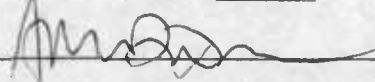

07/84  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14060

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARK A. RAY</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>5 3 19 86</b>		2b. HOUR M <b>5:55 A</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 12 62</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>23 YRS.</b>	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>100 blk. E. Cold Spring Lane</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Hutzler's</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>		13a. STREET ADDRESS <b>1645 Kingsway Road 21218</b>	
13b. COUNTY <b>Maryland</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ocie Ray</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mable Harris</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>218-90-8308</b>		17. INFORMANT ADDRESS <b>Ocie &amp; Mable Ray 1645 Kingsway Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8151</b> IMMEDIATE CAUSE (a) <b>Transected aorta</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:45xx 5-3- 1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Passenger of auto/fixed object impact.</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>100 blk. E. Cold Spring Lane, Balto. City, MD</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER		DATE SIGNED <b>5-3-86</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St., Balto., MD 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5/9/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Nat'l Mem. Pk.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel, MD.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>March Funeral Homes 1101 East North Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 8 1986</b>	
		25b. REGISTRAR'S SIGNATURE 			

1939 NOTION CO.

WIND

WIND



00-05438

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14061

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edwin Earl Raynor			2a. DATE OF DEATH MONTH DAY YEAR 5/1/86			2b. HOUR 6:50A.M.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 6/6/26		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ferndale, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY C & P Telephone	
13a. STATE Maryland				13b. COUNTY AA		13c. CITY OR TOWN Pasadena	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Henry Raynor, Sr.				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Reid			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1944-46		17 INFORMANT ADDRESS Cora W. Raynor, Same as 13			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  2 month
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Joanna D. Brandt, M.D.</u> DEGREE				22c. DATE SIGNED 5/1/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joanna D. Brandt, M.D.	
22e. ADDRESS Mercy Hospital, 301 St. Paul St, Baltimore, MD				22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 5, 1986		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD	
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD				25a. DATE REC'D. BY REGISTRAR MAY 2 1986		25b. REGISTRAR'S SIGNATURE <u>Joanna D. Brandt</u>	

TO HOSPITAL C. TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified about it.

BP

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the efficient operation of any business or organization. This section also outlines the various methods used to collect and analyze data, ensuring that the information is reliable and up-to-date.

2. The second part of the document focuses on the implementation of these record-keeping practices. It provides a detailed description of the systems and procedures that have been developed to streamline the process. This includes the use of specialized software and the establishment of clear guidelines for data entry and review.

3. The third part of the document addresses the challenges associated with maintaining accurate records. It identifies common pitfalls and offers strategies to avoid them. This section also discusses the importance of regular audits and the role of management in ensuring the integrity of the data.

4. The fourth part of the document provides a summary of the findings and conclusions. It highlights the key points discussed throughout the document and offers recommendations for future improvements. This section also includes a list of references and a bibliography of the sources used in the research.

00-05553

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARIA P. RAZURI			2a. DATE OF DEATH MONTH DAY YEAR MAY 3, 1986		2b. HOUR 12:22 M	
3. SEX Female		4. RACE Hispanic		5. DATE OF BIRTH MONTH DAY YEAR 11 - 21-1921		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Peru		7b. CITIZEN OF WHAT COUNTRY? Peru		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Mother				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE Md.		13b. COUNTY City		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST Emilio Corrales		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Santos Carrera		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS Carlos Razuri (same as 13)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIOGENIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>END-STAGE RHEUMATIC HEART DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>12 hours</b> <b>5 years</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>PROBABLE PNEUMONIA</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <u>05/02/1986</u> to <u>05/03/1986</u> , that (1) (we) last saw the deceased alive on <u>05/03/1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)						
22b. SIGNATURE <i>[Signature]</i>		DEGREE MD		22c. DATE SIGNED 05/03/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALIKIS TOGIAS		22e. ADDRESS 600 N WOLF ST BALTO. MD 21205 JOHN HOPKINS HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05-03-1986		23c. NAME OF CEMETERY OR CREMATORY Los Angeles Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE San Pedro Peru		23e. DATE RECD. BY REGISTRAR MAY 5 1986				
24. FUNERAL DIRECTOR NAME Barranco F.H. Sevrna Park, Md. 21146		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be signed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the funeral home and have it filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the physician.

BP



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Burial 05-07-1986 Los Angeles Cem. San Pedro Fern  
 Barranco H. Severna Park, Md. 21146 MAY 5 1986

ALICIA TO GIL

05/07/86  
 05/07/86  
 05/07/86

INTERVIEW BY [illegible]

END-1986 2-1986 1-1986 1-1986

CONFIDENTIAL

CASPER R. [illegible]

None Carlos (name as is)

Willo Corrales Santos Carriere

City Baltimore x 509 Ashburn Ave 21225

House 15 Mother

Perm Perm

Female 11 - 01-1981

F.

00-06163

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8614063  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY C. REBBEL</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 9, 1986</b>		2b. HOUR <b>12<sup>00</sup> P.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 21, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>87</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5837 BELAIR RD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SEAMSTRESS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TAILORING</b>	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY <b>MD.</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5617 PLYMOUTH RD. 21214</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>AUGUST FREY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATHERINE YOUNG</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-14-4036</b>	
17. INFORMANT ADDRESS <b>MRS. ETHEL LAPPE 21206 5908 GRACE AVE</b>		18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>year</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Multiple Traumatic Injuries; Alzheimer's Disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>1/13/81</b> to <b>5/9/81</b> , that (I) (we) last saw the deceased alive on <b>5/18/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Albert B. Bradley</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>May 10, 1986</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBERT B. BRADLEY M.D.</b>		22e. ADDRESS <b>4900 BELAIR RD BALTO MD 21206 ALBERT B. BRADLEY M.D.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5/12/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>	
24. FUNERAL DIRECTOR NAME <b>HARTLEY MILLER</b>		ADDRESS <b>7527 HARTFORD RD.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 12 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-05531

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of case.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 86 14064	
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) <b>Ross c. Redman, Sr.</b>		2b. DATE OF DEATH MONTH DAY YEAR <b>05 04 86</b>	
3. SEX <b>M</b>		4. RACE <b>Can</b>		2c. HOUR <b>5:20 PM</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>May 8 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. BALTIMORE CITY OR COUNTY OF DEATH <b>Balt. City</b> MD.	
9. CITY OR TOWN OF DEATH <b>Randallstown</b>		10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4103 Tiverton Road</b>		11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>	
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>MD.</b> 12b. CITY OR TOWN <b>Baltimore</b> 12c. CITY OR TOWN <b>Randallstown</b>		13. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4103 Tiverton Rd. 21133</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John W. Redman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Harne</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	
16b. SOCIAL SECURITY NO. <b>212-05-7372</b>		17. INFORMANT ADDRESS <b>Ross C. Redman, Jr. 4103 Tiverton Rd.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Resp. Failure/Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <b>May 4</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>5:20 PM</b>					
22b. SIGNATURE <b>[Signature]</b>		22c. DATE SIGNED <b>5/4/86</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Boh Hsiao MD.</b>	
22e. ADDRESS <b>GSH 5601 Loch Raven Blvd.</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-7-1986</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Garden of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Md.</b>		24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>5305 Harford Rd.</b>	
25a. DATE OF REGISTRATION <b>MAY 5 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. REGISTRAR'S NAME <b>[Signature]</b>	

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 01-11-01 BY 60322  
UCBAW



Administrative

Office of the

Director

Washington, D.C.

000-07045

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF A DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. IF THE DEATH OCCURRED AFTER 10:00 P.M. ON FRIDAY, MAY 19, 1986, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH THIS CERTIFICATE. IF THE DEATH OCCURRED AFTER 10:00 P.M. ON FRIDAY, MAY 19, 1986, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH THIS CERTIFICATE. IF THE DEATH OCCURRED AFTER 10:00 P.M. ON FRIDAY, MAY 19, 1986, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH THIS CERTIFICATE. IF THE DEATH OCCURRED AFTER 10:00 P.M. ON FRIDAY, MAY 19, 1986, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH THIS CERTIFICATE.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 14065	
1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERNARD REED SR						2a. DATE KNOWN OF DEATH MATED 5-19-86 19		2b. HOUR 8:30a			
3 SEX male	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 8 12 1895		6. AGE IN YEARS (LAST BIRTHDAY) 90 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 5-19-86 19		7d. HOUR 8:30a				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? U S A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5317 Cordelia Avenue 21215					
14. FATHER'S NAME FIRST MIDDLE LAST Nick Reed		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes							
16a. SOCIAL SECURITY NO. 216-12-5168		17. INFORMANT ADDRESS Esther Harris 2838 Virginia Avenue											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE Margarita A. Korell		TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER		DATE SIGNED 5-19-86					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/23/86		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD					
24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Home West 4300 Wabash Avenue						25a. DATE REC'D. BY REGISTRAR MAY 20 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson					



ONE TO

1130



00-08394

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 0 6 6  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES REED</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5/28/86</b>		2b. HOUR MIN. <b>6:25 A.M.</b>	
3. SEX <b>M</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 25 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>78</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>UNKNOWN</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore city</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH CHARLES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>			13b. COUNTY	13c. CITY OR TOWN <b>BALTIMORE</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT ADDRESS <b>BETTY BONAS 1114 CATHEDRAL ST. 21201</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septic shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>infected Decubitus ulcers Hips</b> DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>congestive Heart Failure; Diabetes Mellitus; Anemia</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <b>5/28 1986</b> to <b>5/28 1986</b> that (I) (we) last saw the deceased alive on <b>5/28 1986</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Marcos B. Galicia Jr. MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>5/28/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARCOS B. GALICIA, JR. MD</b>		22e. ADDRESS <b>North Charles General Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-5-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARRISON FOREST</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>OWING MILLS MARYLAND</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>WM.C. MARCH F/H INC, 1101 E. NORTH AVENUE</b>				
25a. DATE RECD. BY REGISTRAR <b>JUN 4 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Thereafter, please remove carbon papers. Pages which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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100% COTTON

100% COTTON

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100% COTTON



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6  
REG. NO.

1 4 0 6 7

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELSIE ELEANOR REEDER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>5/25/86</b>		2b. HOUR <b>0710</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>03 08 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>							
13a. USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY OR TOWN <b>Maryland A.A. Glen Burnie</b>				13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216 30 7944</b>		17. INFORMATION ADDRESS <b>Glen Burnie, Maryland 21061</b> <b>Joe Reeder 413 Wirth Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sepsis.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>perforated colonic cancer.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>liver failure</u>							
19a. DATE OF OPERATION <b>5/1/86</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>colonic obstruction</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>on 5/25/86</u> , 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>5/25/86</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (I) (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jayesh R. Shah</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>5/25/86</b>	
22d. ADDRESS <b>St. Agnes Hospital Baltimore, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/28/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Raymond C. Fink Glen Burnie, Md 21061</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>MAY 26 1986 Julie Davidson</b>			

STATE DEPARTMENT

WASHINGTON, D. C.

OFFICE OF THE ATTORNEY GENERAL

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00-07244

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 0 6 8  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARY PATRICIA REVILLE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>05 20 88</b>		2b. HOUR <b>2300AM</b>								
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 18, 1934</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>							
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOOD SAMARITAN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>EDUCATION</b>					
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>21234</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8627 RICHMOND AVE. 21234</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN HENRY O'KEEFE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CHARLOTTE BLACK</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-32-4172</b>		17. INFORMANT ADDRESS <b>GERALD P. REVILLE 21234 8627 RICHMOND AVE.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Breast Carcinoma to Liver &amp; Bones</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a: _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>230 P.M. 5 20 1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22a. SIGNATURE <b>Robert Hsiao MD.</b>					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5-20-86</b>				
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Hsiao</b>					22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>MAY 24, '86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DULANEY VALLEY MEM. GAR.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CO., MD</b>					
24. FUNERAL DIRECTOR NAME <b>WILLIAM E. JOHNSON</b>					ADDRESS <b>8521 LOCH RAVEN BLVD.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 21 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Gelia Davidson-Randall</b>				

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP \_\_\_\_\_

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00-07860

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. crs checked  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.DHMH - 16 60M 7/84  
(VRA 15, 4)FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 14069

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hong Ki Rhee			2a. DATE OF DEATH MONTH DAY YEAR MAY 27 1986		2b. HOUR A 3:50 M.
3. SEX MALE	4. RACE KOREAN	5. DATE OF BIRTH MONTH DAY YEAR AUG 12 1909	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KOREA	7b. CITIZEN OF WHAT COUNTRY? MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRO	12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2000 ODELL AVE 21237	
14. FATHER'S NAME FIRST MIDDLE LAST Duk K. Rhee	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sookyoung Kin	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 216 826 518		17. INFORMANT ADDRESS FAMILY RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gary K. Rhee MD				22c. DATE SIGNED MAY 27 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY K. RHEE				22e. ADDRESS CHURCH HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 29 1986	23c. NAME OF CEMETERY OR CREMATORY DUBLANZY VALLEY		23d. LOCATION CITY OR TOWN COUNTY STATE TIMONION BALTO. MD.
24. FUNERAL DIRECTOR NAME EVANS CHAPLAIN OF CHIMES YORK RD.		25a. DATE REC'D BY REGISTRAR MAY 28 1986		25b. REGISTRAR'S SIGNATURE June Carson	

BP \_\_\_\_\_



THE UNIVERSITY OF CHICAGO  
 LIBRARY  
 525 EAST 58TH STREET  
 CHICAGO, ILL. 60637

Dear Sir,  
 I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above matter.  
 I am sorry to hear that you are having trouble with the machine.  
 I will be glad to send you a new one if you wish.  
 Very truly yours,  
 J. H. Smith

Yours truly,  
 J. H. Smith  
 President

0-08453

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR <b>WALTER ALLEN RHODE</b>										
1. DECEASED NAME (TYPE OR PRINT) <b>Walter Allen Rhode</b>					2a. DATE OF DEATH MONTH <b>5</b> DAY <b>31</b> YEAR <b>86</b>		2b. HOUR <b>2:30PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>August</b> DAY <b>22</b> YEAR <b>1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Self Employed-Import</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Business</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>13 Overbrook Road 21228</b>	
14. FATHER'S NAME FIRST <b>Martin</b> MIDDLE <b>Rhode Jr.</b> LAST <b>Rhode Jr.</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Annie</b> MIDDLE <b>Klees</b> LAST <b>Klees</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-05-1920</b>		17. INFORMANT ADDRESS <b>Mrs. Sarah Rhode Same as # 13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypoxia</b> DUE TO, OR AS A CONSEQUENCE OF <b>COPD</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>5-22</b> , 19 <b>86</b> , to <b>5-31</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5-31</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If "we" did I did not view the body after death)										
23a. SIGNATURE <b>Dr. Gregory Gordon, MD</b>				23b. DEGREE <b>MD</b>				23c. DATE SIGNED <b>5-31-86</b>		
23d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Gregory Gordon, MD</b>				23e. ADDRESS <b>St. Agnes Hospital, Baltimore, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/3/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION CITY OR TOWN <b>Woodlawn</b> COUNTY <b>Maryland</b> STATE <b>Maryland</b>		23e. DATE REG'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE		
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b> <b>1630 Edmondson Avenue, Catonsville, MD. 21228</b>										

10% COLON

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00-07181

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 4 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALSO, WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14071

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Jasper						Richardson, Jr		5/ 19/ 86		5/		19/		86		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	black	9 28 1928		57 YRS.						5/ 19/ 86		5/		19/		86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
S.C.		U S A		WIDOWED		DIVORCED		Baltimore City,								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		Lutheran Hospital		Janitor		Diamond Cab Co											
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2815 W. North Avenue 21216									
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST			
Jasper						Richardson		Martha						Richardson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		250-01-8793		Helen Richardson		2815 W. North Avenue											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Ruptured Abdominal Aorta Aneurysm																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?	
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
22b. TITLE (SPECIFY) Assistant MEDICAL EXAMINER																	
22c. DATE REC'D. BY REGISTRAR MAY 21 1986																	
22d. REGISTRAR'S SIGNATURE																	
22e. EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				5/23/86				Garrison Forest Vet				Owings Mills MD					
24. FUNERAL DIRECTOR March Funeral Home West 4300 Wabash Avenue																	

OFFICE OF THE SECRETARY OF THE ARMY

10-11-10

10-11-10



00-05872

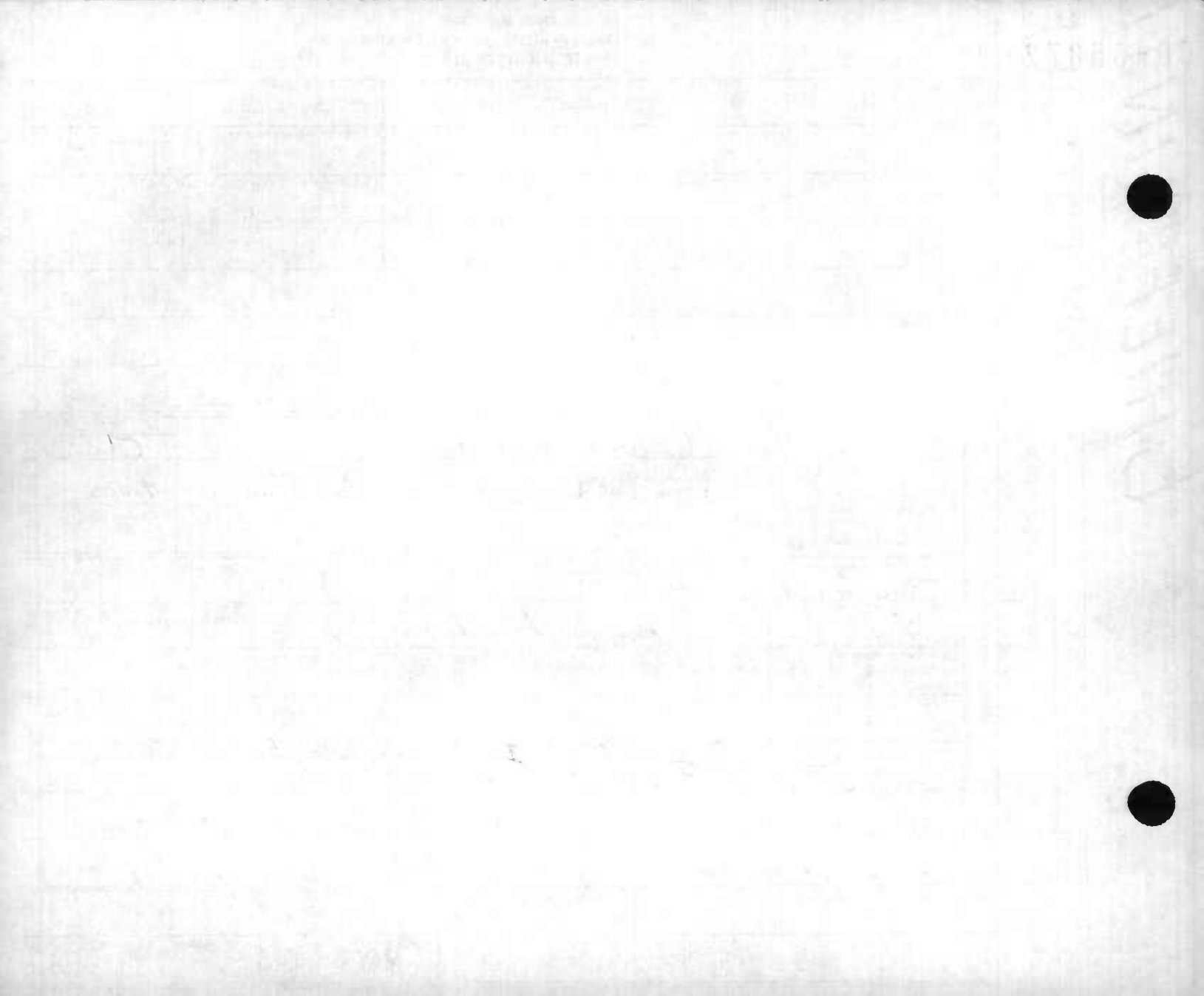
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. REG. NO.		8 6 1 4 0 7 2					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAUREN N RICHARDSON				2a. DATE OF DEATH MONTH DAY YEAR MAY 5, 1986				2b. HOUR 03:05am	
3. SEX female		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 7 23 1985		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 9		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2516 W. Coldspring Lane 21215			
14. FATHER'S NAME FIRST MIDDLE LAST Wardell L. Richardson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christianna C. Bean					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-08-2219		17. INFORMANT ADDRESS Christianna Bean 2516 W. Coldspring Lane					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Primitive Neuroectodermal Brain Tumor DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Thrombocytopenia, Anemia									
19a. DATE OF OPERATION 4/11		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Airway Management-Tracheostomy				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from March 29, 19 86, to May 5, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, state date and hour when death occurred.)									
22b. SIGNATURE Gerald V. Raymond				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/5/86	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) GERALD V. RAYMOND				22e. ADDRESS 600 N WOLFESTREET JOHNS HOPKINS BALT, MD 21205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/8/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co Md			
24. FUNERAL DIRECTOR NAME March Funeral Home West 4300 Wabash Avenue				25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 6 1986					





00-08548

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 0 7 3  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT RICHMOND			2a. DATE OF DEATH MONTH DAY YEAR MAY 31, 1986			2b. HOUR 10:32 <sup>A</sup>			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 30 25		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1613 N. Spring Street 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Richmond				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Roosevelt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217-24-6936		17. INFORMANT ADDRESS Robert R. Richmond 1613 N. Spring Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <u>hypertension</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/21</u> , 19 <u>86</u> , to <u>5/31</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5/31</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Waiter N. Kernan MD</u>				DEGREE MD				22c. DATE SIGNED 5/31/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Waiter N. Kernan				22e. ADDRESS 600 N. Wolfe St. BALTO MD 21205 <u>90 Johns Hopkins Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/6/86		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD.		25a. DATE RECEIVED BY REGISTRAR JUN 5 1986	
24. FUNERAL DIRECTOR NAME March Funeral Homes 1101 E North Avenue				25b. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION

RELEASED AS NON-RECORDED BY DB. KAUFFMANN, PER MR. RICHARDSON  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-07178

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 4 0 7 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dolores C. Rick's			2a. DATE OF DEATH MONTH DAY YEAR 5 16 86			2b. HOUR 8 06 PM				
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 9 25 33		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) Balt W		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.				
10. CITY OR TOWN OF DEATH Balt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ of Maryland				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY Balt		13c. CITY OR TOWN Balt		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2410 Harlem Ave 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE Mary A. TUTT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 219-28-2159			17. INFORMANT Veronica Blount 2410 Harlem Avenue				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Squamous Cell Cancer of Lung DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/16/86 to 5/16/86, that (I) (we) last saw the deceased alive on 5/16/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)										
22b. SIGNATURE Jonathan D Root			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/19/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jonathan D Root			22e. ADDRESS Univ of Maryland Hosp.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/22/86		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD			
24. FUNERAL DIRECTOR NAME March Funeral Home West 4300 Wabash Avenue						25a. DATE REC'D. BY REG. CLERK MAY 21 1986				

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the pages and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by doctor.

100% COTTON  
MADE IN U.S.A.  
100% COTTON  
MADE IN U.S.A.



00-05836

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14075

REG. NO.

1. STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
JAMES O. RIFFLE		5-2-86		3:57 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. IF UNDER 1 YEAR	
Male	caucasian	5-9-1899	86	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH		
W. VA	U.S.A.	NEVER MARRIED	City Balto. MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	SBGlt Balto. Md.	Urban Transp. Ret.		Engineer, R.R.	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MARYLAND		BALTIMORE	YES	Balto. Md. 1537 COVINGTON ST 21230	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES?			
NONE	UNKNOWN	No			
16a. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
70507.5032	CHARL, Mrs. Dicie J. Riffle	Same as 13			
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardiac arrest					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
(b) SEPSIS					
DUE TO, OR AS A CONSEQUENCE OF					
(c) Pneumonia, Urinary Tract Infection					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
Acute Renal Failure, GI Bleed					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES	YES		
21a. ACCIDENT WAS UNDERLYING	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED			
OR CONTRIBUTING CAUSE OF DEATH	HOUR A.M. MONTH DAY YEAR	(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
(IF EITHER, NOTIFY MEDICAL EXAMINER)	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY	21f. LOCATION			
WHILE AT WORK	(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from	22b. SIGNATURE				
5/2/86	Basil E. Chryssos M.D.				
22c. DATE SIGNED	22d. PHYSICIAN'S NAME				
5/2/86	BASIL E. CHRYSSOS M.D.				
22e. ADDRESS	23a. BURIAL, CREMATION, REMOVAL				
SBGlt	(SPECIFY) Burial				
23b. DATE	23c. NAME OF CEMETERY OR CREMATORY				
5/6/1986	Meadowridge Cent.				
23d. LOCATION	23e. DATE REC'D. BY REGISTRAR				
Elkridge, Howard Co., Md.	MAY 6 1986				
24. FUNERAL DIRECTOR	25a. REGISTRAR'S SIGNATURE				
Balto. Md. 21230	McCully Funeral Home, 130 E. Fort Ave.				

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.





00-076751

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14076

1. DECEASED NAME (TYPE OR PRINT)			FIRST Robert			MIDDLE Francis			LAST Riley			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-25 1986			2b. HOUR M 8:45 a.m.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 9, 1963		6. AGE (IN YEARS) LAST BIRTHDAY 22 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-25 1986		2d. HOUR M 8:45 a.m.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2000 blk. Lydonlea Way								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student				12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. STATE Maryland				13b. COUNTY ---				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 1646 Sherwood Ave. 21239			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Lawrence Riley						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Helen Latavitz													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 217-92-1717						17. INFORMANT ADDRESS R.L.Riley 1646 Sherwood Ave. 21239							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY (est.) HOUR A.M. MONTH DAY YEAR ? P.M. 5-25 1986				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject inhaled exhaust from auto											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) auto				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2000 blk. Lydonlea Way, Balto., Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>Dennis F. Smyth M.D.</i> TITLE (SPECIFY) Assistant MEDICAL EXAMINER														DATE SIGNED 5-25-86					
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.														ADDRESS 111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-28-86				23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Maryland							
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefled Home 6500 York Road 21212														25a. DATE REC'D. BY REGISTRAR MAY 27 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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THE WORLD OF THE FUTURE

00-06424

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carefully pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DIANA M. Robbins</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 9, 1986</b>		2b. HOUR <b>4:40 PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 8, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deaton Hosp + Med. Center Balto.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Factory Worker</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>---</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown --- Stanley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-07-5564</b>		17. INFORMANT ADDRESS <b>Mr. James K. Robbins, Same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis infected left leg</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SIP MI congestive heart failure</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <b>18 April 1986</b> , to <b>7 May 1986</b> , that (I) (we) last saw the deceased alive on <b>2 May 1986</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.					
22b. SIGNATURE <b>JW Reed M.D.</b>		DEGREE		22c. DATE SIGNED <b>5/12/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JW REED M.D.</b>		22e. ADDRESS <b>611 S. CHAS. ST. BALTO. MD. 21238</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/13/1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemt.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. A.A. Co. Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>McCuilly Funeral Home, 130 E. Fort Ave. Balto. Md. 21230</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>MAY 13 1986</b>	

1986

May 3, 1986

Robbins

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1986

00-06990

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST JABARI A ROBERTS					MONTH DAY YEAR 5 / 15 / 86				
3. SEX MALE					4. RACE BLACK				
5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)				
MONTH DAY YEAR 8 19 85					IF UNDER 1 YEAR MONTHS DAYS 8 26				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD					7b. CITIZEN OF WHAT COUNTRY? USA				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE CITY					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND HOSPITAL				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MARYLAND					13b. CITY OR TOWN BALTIMORE				
13c. STREET ADDRESS / ZIP CODE 2228 MT ROYAL TERR, Apt 2, 21217					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST Eric N. Roberts					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aletta Royal				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO NA				
17. INFORMANT ADDRESS Aletta Saunders 2228 Mt Royal Terrace									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>									
DUE TO, OR AS A CONSEQUENCE OF									
b) <u>CARDIOMYOPATHY, PULMONARY EDEMA</u>									
DUE TO, OR AS A CONSEQUENCE OF									
c) <u>ACQUIRED IMMUNE DEFICIENCY SYNDROME, NEPHROTIC SYNDROME, TUBERCULOSIS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>THROMBOCYTOPENIA - NO SEPSIS</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/9/86</u> to <u>5/15/86</u> , that (I) (we) lost saw the deceased alive on <u>5/15/86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Sanjiv Sur</u>					DEGREE MD			22c. DATE SIGNED 5/15/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANJIV SUR					22e. ADDRESS 5E, DEPT OF PEDIATRICS, UNIVERSITY OF MARYLAND HOSPITAL, BALTIMORE				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/20/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION Anne Arundel Co Md		
24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Home West 4300 Wabash Avenue					25a. DATE REC'D. BY REGISTRAR MAY 19 1986		25b. REGISTRAR'S SIGNATURE		

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00-078011- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 0 7 9  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARROLL ) ROBERTSON			2a. DATE OF DEATH MONTH DAY YEAR 5 25 86		2b. HOUR 1013 AM	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 7 10 08		
6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CALIFORNIA		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSPITAL		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Captain		12b. KIND OF BUSINESS OR INDUSTRY Tanker				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE MD		13b. COUNTY BALT.		13c. CITY OR TOWN PASADENA		
14. FATHER'S NAME FIRST MIDDLE LAST ERNEST ROBERTSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOU GRANGER		13d. STREET ADDRESS / ZIP CODE 7872 BELHAVEN RD. 21122		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 552-22-6253		17. INFORMANT ADDRESS 7872 Bellhaven Rd. Ms. Louise Palaski Pasadena, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SMALL BOWEL OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF (b) PANCREATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Michael E. Collier, MD		DEGREE		22c. DATE SIGNED 5/25/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E. COLLIER		22e. ADDRESS 3001 SOUTH HANOVER ST.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 5-25-86		23c. NAME OF CEMETERY OR CREMATORY		
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR MAY 28 1986		23f. REGISTRAR'S SIGNATURE		
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the local examiner must be notified at once.

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WINTER 1900





00-06697

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14080

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANDREW ROBINSON			2a. DATE OF DEATH 5/13/86			2b. HOUR 10 <sup>35</sup> PM		
3 SEX FEMALE	4 RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 3 2 34			6 AGE (IN YEARS LAST BIRTHDAY) 52 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MED CTR				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COSMETOLOGIST		12b KIND OF BUSINESS OR INDUSTRY

13a. STATE MD			13b. COUNTY BALTIMORE			13c. CITY OR TOWN CITY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 21229 3600 W. FRANKLIN ST.		
14 FATHER'S NAME FIRST MIDDLE LAST ANDREW WELBOURNE			15 MOTHER'S MAIDEN NAME MIDDLE LAST DARNETTA SMOTHER			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. 220 30 1826			17 INFORMANT ADDRESS CONSUELLA S. WILDER 3406 LYNCHES TER RD. BALTIMORE, MD, 21215		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) abdominal abscess DUE TO, OR AS A CONSEQUENCE OF (c) Subtotal gastrectomy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days none month 3 months
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic renal failure, Renal Transplant.			
19a. DATE OF OPERATION 5/8/86	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal abscess	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/13/86, 1986, to 5/13/86, 1986, that (I) (we) last saw the deceased alive on 5/13/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Warren R. Maley MD		DEGREE MD	22c. DATE SIGNED 5/13
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WARREN R. MALEY		22e. ADDRESS FSKMC	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5/17/86	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD.
24. NAME OF FUNERAL HOME NAME ADDRESS 2501 GWYNNE FALLS PKWY. BALTO, MD.		25a. DATE REC'D. BY REGISTRAR MAY 15 1986	25b. REGISTRAR'S SIGNATURE Julia Davidson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



00-07179

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14081

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Carrie Robinson			2a. DATE OF DEATH MONTH DAY YEAR 05 19 86			2b. HOUR 12:15 <sup>AM</sup>			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 08 15 67		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.			
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ of Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY	

13a. STATE Md			13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1010 W. Baltimore St 21223		
14. FATHER'S NAME FIRST MIDDLE LAST Robert N. Son						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Smith								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-14-6661				17. INFORMANT ADDRESS John Robinson 1010 W. Baltimore St						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Renal Failure</u>											
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19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					

22a. I certify that (I) (this hospital) attended the deceased from <u>5/11</u> , 19 <u>86</u> , to <u>5/19</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5/18</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
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22b. SIGNATURE <u>Neil Padgett MD</u>						DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Neil Padgett</u>						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. ADDRESS <u>Univ of Md Hospital 225 Greene St</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/24/86		23c. NAME OF CEMETERY OR CREMATORY Eastview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD	
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24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Home West 4300 Wabash Avenue				25a. DATE REC'D. BY REGISTRAR MAY 21 1986		25b. REGISTRAR'S SIGNATURE	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or hospital, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy, page 4, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



10-07755

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 0 8 2  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DEANNA MIDDLE ROBINSON</b> <i>Deanna Robinson</i>		2a. DATE OF DEATH May 22, 1986 05 02 86		2b. HOUR 9 <sup>30</sup> P.M.	
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH 02 13 38 2 13 38		6. AGE (IN YEARS LAST BIRTHDAY) 48 48 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Sinai Hospital of Baltimore</b> <i>SINAI OF BALTIMORE</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Billing</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Md. State</b>
13a. STATE <b>Maryland</b>		13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur Hamilton</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie Lee Wooden</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>259-60-9238</b>		17. INFORMANT ADDRESS <b>Pettis Robinson 5 N. Monastery St. 21229</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ischemic lung carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Frederick J. Venable</i>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FREDERICK J VENABLE</b>		22e. ADDRESS <b>SINAI OF BALTIMORE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>5-31-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Balto. Co., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Marshall W. Jones, Jr.</b>		24b. ADDRESS <b>4101 Edmondson Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 27 1986</b>	
24c. CITY OR TOWN <b>Baltimore</b>		24d. STATE <b>Md.</b>		25b. REGISTRAR'S SIGNATURE <i>Julie Darden-Robinson</i>	

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Leslie Robinson & H. W. Roberts

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Archie McNeill & Co., Architects, Dallas, Tex.

11-10-68  
J. Edgar Hoover, Director  
Federal Bureau of Investigation  
Washington, D.C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, fill in the name of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the funeral home. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. The medical examiner's report should be filed with the State Dept. of Health and Mental Hygiene. The medical examiner's report should be filed with the State Dept. of Health and Mental Hygiene. The medical examiner's report should be filed with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner's report should be filed with the State Dept. of Health and Mental Hygiene.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 4 0 8 3 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) DAVID ROBISON										2a. DATE OF DEATH MONTH DAY YEAR MAY 27, 1986		2b. HOUR 7:15 7L15 M					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 18, 1937		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.											
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSULTANT		12b. KIND OF BUSINESS OR INDUSTRY LABOR									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND										13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3905 CANTERBURY RD. #21218	
14. FATHER'S NAME FIRST MIDDLE LAST EMANUEL ROBINSON					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE NEWMAN												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 068-30-5250 413-08-4054		17. INFORMANT MRS. PHYLLIS ROBISON 3905 CANTERBURY RD. BALTO., MD 21218										
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonia with sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (c) Burkitt's Type Lymphoma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 5-20 min 7 Feb 1986							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Lymphomatous meningitis. 5/12/86.																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from 5/12, 1986, to 5/27, 1986, that (I) (we) last saw the deceased alive on 5/27, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Shanta Purcell					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 5/27/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Shanta Purcell					22e. ADDRESS Johns Hopkins Hospital												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL/ BURIAL		23b. DATE MAY 29, 1986		23c. NAME OF CEMETERY OR CREMATORY MT. PLEASANT WESTCHESTER				23d. LOCATION CITY OR TOWN COUNTY STATE HAWTHORNE NEW YORK									
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215					25a. DATE REC'D. BY REGISTRAR JUN 4 1986							25b. REGISTRAR'S SIGNATURE Julia Davidson-Hopkins					



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6  
00-07446STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14084

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH MATED		<input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
Gordon		A.		Roe				5/ 19/ 86		9:47		P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD	
Male		White		July 21 1944		41 YRS.						5/ 19/ 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Texas		U.S.A.				Baltimore City,						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		University Hospital		Court Judge		Law							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Penna.		YORK						2436 Wildon Dr.		17403			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Warren		A.		Roe		Janet				Gordon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		Viet-Nam		200-34-0563		Etzweiler F. H.		York Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5/ 17/ 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject operator of tractor that overturned pinning him beneath it.									
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) field		21f. LOCATION 1/10 mile West of Flintville Rd., Peach Bottom Township, Pennsylvania.									
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 5/20/86							
ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT)		Gregory Kaufman M.D.		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Removal-Burial		5-23-86		Slateville		York		Delta		Pa.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Henry W. Jenkins		Sons Co., Balto., Md.		MAY 23 1986		John Davidson							

DIVISION OF VITAL RECORDS, 401 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 401 W. PRESTON STREET,  
BALTIMORE, MARYLAND 21201, FOR OR TO BURIAL, CREMATION, OR REMOVAL.BP  
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10M-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14085	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GLADYS MAE ROGERS							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 21 19 86		2b. HOUR M 11:21		
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 4 9 08	6. AGE (IN YEARS) LAST BIRTHDAY 78 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD 5 21 19 86		2d. HOUR M 11:21			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2706 Greenmount Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2706 GREENMOUNT AVE. 21218			
14. FATHER'S NAME FIRST MIDDLE LAST HARRY EDWARDS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HARRIET HALL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212220873		17. INFORMANT ADDRESS JESSE ROGERS 2706 GREENMOUNT AVE.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED May 21, 86			
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, MD		ADDRESS 111 Penn Street, Balto, MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-28-86		23c. NAME OF CEMETERY OR CREMATORY GARRISON FORREST		23d. LOCATION CITY OR TOWN COUNTY STATE OWING MILLS MARYLAND					
24. FUNERAL DIRECTOR NAME ADDRESS WM.C.MARCH FUNERAL HOME INC. 1101 E. NORTH AVE.				25a. DATE REC'D. BY REGISTRAR MAY 27 1986		25b. REGISTRAR'S SIGNATURE 					

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NOTICE 202

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00-07842

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 4 0 8 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Cyrus Anthony Rolling III			2a. DATE OF DEATH MONTH DAY YEAR 05/22/86		2b. HOUR 9:26 PM		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 04 20 86		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. YRS. 1 2	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 20737 6357 apt. F4 64th Ave		14. FATHER'S NAME FIRST MIDDLE LAST Cyrus Anthony Rolling, Jr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST D. Valerie Bullock		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. None		17. INFORMANT Patient Record		17. ADDRESS			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 15 min	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		36 hours	
(b) Hyperkalemia / Renal Failure		40 hours	
(c) Sepsis			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Intracranial Hemorrhage of Brain, Extreme Prematurity, Respiratory Distress Syndrome			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from May 1, 19 86, to May 22, 19 86, that (I) (we) last saw the deceased alive on May 22, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Lillian R. Blackmon, M.D.		DEGREE		22c. DATE SIGNED 05/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lillian R. Blackmon, M.D.		22e. ADDRESS 225. Greene Street, Univ. Md. Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 28, 1986		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Maryland	
24. FUNERAL DIRECTOR NAME Stewart Funeral Home-4001 Benning Road, N.E.		25a. DATE REC'D. BY REGISTRAR MAY 28 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, all medical attention and the medical history.

BP

00-11843

RECEIVED OCT 10 1964

UNITED STATES DEPARTMENT OF JUSTICE



EX-100



0-05745

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14087

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ralph		FIRST J.		MIDDLE Rook		LAST		2a. DATE OF DEATH MONTH DAY YEAR 5 2 86		2b. HOUR 2:50 AM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01/19/07		6. AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber		12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md				13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4012 Hickory Avenue 21211	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Rook				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Reed							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 05 3199		17. INFORMANT Hazel M. Rook				ADDRESS same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from <u>May 2, 1986</u> to <u>May 2, 1986</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>May 2, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22a. SIGNATURE <u>John Thomas Evelius</u>				DEGREE MD				22b. DATE SIGNED 5/2/86			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN THOMAS Evelius, MD				22d. ADDRESS Union Memorial Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05/05/86		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hamstead, Carroll Co. Md.					
24. FUNERAL DIRECTOR NAME Burge-Henss Funeral Home 3631 Falls Rd. 21211						25a. DATE REC'D. BY REGISTRAR MAY 6 1986		25b. REGISTRAR'S SIGNATURE <u>John Thomas Evelius</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES

NAVY DEPT



RECEIVED 10-10-52

00-06993

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send it to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) David E. Rose					2a DATE OF DEATH MONTH DAY YEAR 5 15 86		2b HOUR M		
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 8 7 28		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3513 Spaulding Avenue				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Md.		13b COUNTY Balto.		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS / ZIP CODE 3513 Spaulding Avenue 21215			
14 FATHER'S NAME FIRST MIDDLE LAST Robert Rose				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie English					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 250-42-6244		17 INFORMANT Rebecca Rose		ADDRESS 3513 Spaulding Avenue			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC LUNG CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 years.</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DM / HYP / CAD</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital attended the deceased from <u>7/29/81</u> to <u>5/15/86</u> , that (I) (we) lost saw the deceased alive on <u>4/18/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b SIGNATURE <u>B. A. Cockman, M.D.</u>				DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>5-16-86</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>B. A. Cockman, M.D.</u>				22e ADDRESS <u>6806 PAUL HIGGINS AVE. BALTO, MD 21225</u>					
23a BURIAL, CREMATION, REMOVAL (CHECK IF ) Cremation		23b DATE 5/16/86		23c NAME OF CEMETERY OR CREMATORY Westview Mem. Pk.		23d LOCATION CITY OR TOWN COUNTY STATE Catonsville, Md.			
24 FUNERAL DIRECTOR NAME Wm C March F. H West				ADDRESS 4300 Wabash Ave.		25a DATE REC'D. BY REGISTRAR MAY 19 1986		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place the remaining pages, pages 1 and 2, in the envelope and return to the State Dept. of Health and Mental Hygiene prior to burial with the deceased. Pages 1 and 2 should be filled within 72 hours after death with the attending physician's signature and the funeral director's removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												86	14089		
FOR 1 - STATE REGISTRAR				REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) Gillmore B Rose				2a. DATE OF DEATH MONTH DAY YEAR 5/24/86				2b. HOUR 759 AM							
3. SEX M		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 11 25 14				6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN) virginia?		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 1629 N. Calhoun St. 21217			
14. FATHER'S NAME FIRST MIDDLE LAST W N K				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie XXXXXX Rose											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW II		17. INFORMANT ADDRESS Elmer R. Murray 3 Kittridge Ct. Randallstown									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/24 19 86 to 5/24 19 86, that (I) (we) last saw the deceased alive on 5/24 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE S Papachis mo								DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/24/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Garg C Papachis								22e. ADDRESS 225 Greene St Balt mo							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-29-86		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, Maryland					
24. FUNERAL DIRECTOR NAME Bailey Funeral Home 1348 N. Calhoun St. 21217								25a. DATE OF DEATH MAY 28 1986						25b. REGISTRAR'S SIGNATURE J. W. Harrison	

10-10-10

ROSS COLON

WATKINS



10-10-10

00-07214

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 0 9 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEON ROSENTHAL			2a. DATE OF DEATH MONTH DAY YEAR 5 16 86		2b. HOUR 11:54 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 4 22		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. CITY OR TOWN BALTO.		13c. INSIDE CITY LIMITS? NXX	
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL ROSENTHAL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRIEDA RUBENSTEIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.		17. INFORMANT MRS. SONIA ROSENTHAL 7404 RICKSWAY RD. BALTO., MD 21208	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC COLON CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I DM						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I (this hospital) attended the deceased from 9/20 19 86, to 5/16 19 88, that (I (we) last saw the deceased alive on 5/16 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I (we) did) (did not) view the body after death.						
22b. SIGNATURE Mark A. Goldstein, MD		DEGREE		22c. DATE SIGNED 5/16/88		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK A. GOLDSTEIN, MD		22e. ADDRESS SINAI HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 18, 1986		23c. NAME OF CEMETERY OR CREMATORY TIFERETH ISRAEL ANSHE SFARD		
23d. LOCATION TOWN COUNTY STATE ROSEDALE BALTO. MD		24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				
25a. DATE REC'D. BY REGISTRAR MAY 21 1986		25b. REGISTRAR'S SIGNATURE John Davidson				

MEDICAL CERTIFICATION

7/29/88

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



00-005514

30% COTTON FIBER

DAVID W. ALLEN



0-07838

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14091

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR															
1. DECEASED NAME (TYPE OR PRINT) Lorenzo Ross, Jr.										5-24		19		86															
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 19 48		6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.		IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 5-24 19 86		2d. HOUR 1:00 a.m.															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.																	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed				12b. KIND OF BUSINESS OR INDUSTRY																	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3706 Gelston Dr. 21229											
14. FATHER'S NAME FIRST MIDDLE LAST Lorenzo Ross, Sr.										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janie Dennison																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO.										17. INFORMANT ADDRESS Janie Ross 3706 Gelston Dr.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Abdomen DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:20X 5-24 19 86				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject was shot																					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION CITY OR TOWN COUNTY STATE 1200 blk. of Laurens St., Balto., Md.																					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .																													
ACTUAL SIGNATURE Dennis F. Smyth, M.D.										TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 5-24-86															
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.										ADDRESS 111 Penn St., Balto., Md. 21201																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/28/86		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.																			
24. FUNERAL DIRECTOR NAME West Wm C March F/H.										ADDRESS 4302 Wabash Ave.				25a. DATE REC'D. BY REGISTRAR MAY 28 1986		25b. REGISTRAR'S SIGNATURE													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))

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CHIEF WINTER

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00-06409

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 0 9 2

1. DECEASED NAME (TYPE OR PRINT) <b>MYRTLE A. ROSS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5-12-86</b>		2b. HOUR <b>12:25 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8-7-1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Canada</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse - Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Spring Grove State Hospital</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Fred Clark</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Adelia Sparks</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-14-1746</b>		17. INFORMANT ADDRESS <b>Shirley S. January 2827 Erdman Ave.-21213</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock, sepsis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>5/12</b> , 19 <b>86</b> , to <b>5/12</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/12</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Bich T Duong</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>5-12-86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BICH T DUONG</b>				22e. ADDRESS <b>LUTHERAN HOSPITAL</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-15-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>John C. Miller Inc. 6415 Belair Rd. 21206</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 13 1986</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

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00-08429

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 14093  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SHIRLEY RUTH ROTHSCHILD			2a. DATE OF DEATH MONTH DAY YEAR 5 30 86			2b. HOUR 3:25 P.M.	
3. SEX F FEMALE		4. RACE W WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 4 33		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA		16. MR. IRVIN ROTHSCHILD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-28-7436		17. INFORMANT 6624 SANZO RD., APT. B #21209			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC BREAST CANCER DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/28, 19 86, to 5/30, 19 86, that (I) (we) last saw the deceased alive on 5/30, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. A. Goldstein MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GOLDSTEIN				22e. ADDRESS SINAI HOSPITAL			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-1-86		23c. NAME OF CEMETERY OR CREMATORY AITZ CHAIM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR JUN 4 1986	
25b. REGISTRAR'S SIGNATURE John Davidson-Randall							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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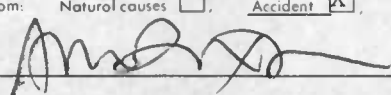
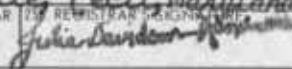
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00-07052

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14094

1. DECEASED NAME (TYPE OR PRINT) <b>MARY Elizabeth ROWE</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>5 13 1986</b>			2b. HOUR <b>8:43 P.M.</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 24, 1969</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>16 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>5 13 1986</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) <b>University Hosp. - STU (DOA)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Perryville High School</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Colona</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>516 Colona Road 21917</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Nelson Rowe</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Leuretha Blankenship</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-----</b>			17. INFORMANT ADDRESS <b>William Nelson Rowe, Colona, Maryland.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8120 IMMEDIATE CAUSE (a) Thoracic trauma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <del>XX</del> MONTH DAY YEAR <b>7:10 P.M. 5-13- 1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver of auto/auto collision.</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 1 Cecil MD</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>5-14-86</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>			ADDRESS <b>111 Penn St., Balto., MD 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 17, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marks Church Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Perryville, Cecil Maryland</b>		
23e. DATE REC'D. BY REGISTRAR <b>MAY 20 1986</b>					23f. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

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on 17, 1968 to John French, Jr.

Line

John A. Robertson, Jr., 1900-1901, 1902-1903, 1904-1905, 1906-1907, 1908-1909, 1910-1911, 1912-1913, 1914-1915, 1916-1917, 1918-1919, 1920-1921, 1922-1923, 1924-1925, 1926-1927, 1928-1929, 1930-1931, 1932-1933, 1934-1935, 1936-1937, 1938-1939, 1940-1941, 1942-1943, 1944-1945, 1946-1947, 1948-1949, 1950-1951, 1952-1953, 1954-1955, 1956-1957, 1958-1959, 1960-1961, 1962-1963, 1964-1965, 1966-1967, 1968-1969, 1970-1971, 1972-1973, 1974-1975, 1976-1977, 1978-1979, 1980-1981, 1982-1983, 1984-1985, 1986-1987, 1988-1989, 1990-1991, 1992-1993, 1994-1995, 1996-1997, 1998-1999, 2000-2001, 2002-2003, 2004-2005, 2006-2007, 2008-2009, 2010-2011, 2012-2013, 2014-2015, 2016-2017, 2018-2019, 2020-2021, 2022-2023, 2024-2025, 2026-2027, 2028-2029, 2030-2031, 2032-2033, 2034-2035, 2036-2037, 2038-2039, 2040-2041, 2042-2043, 2044-2045, 2046-2047, 2048-2049, 2050-2051, 2052-2053, 2054-2055, 2056-2057, 2058-2059, 2060-2061, 2062-2063, 2064-2065, 2066-2067, 2068-2069, 2070-2071, 2072-2073, 2074-2075, 2076-2077, 2078-2079, 2080-2081, 2082-2083, 2084-2085, 2086-2087, 2088-2089, 2090-2091, 2092-2093, 2094-2095, 2096-2097, 2098-2099, 2100-2101, 2102-2103, 2104-2105, 2106-2107, 2108-2109, 2110-2111, 2112-2113, 2114-2115, 2116-2117, 2118-2119, 2120-2121, 2122-2123, 2124-2125, 2126-2127, 2128-2129, 2130-2131, 2132-2133, 2134-2135, 2136-2137, 2138-2139, 2140-2141, 2142-2143, 2144-2145, 2146-2147, 2148-2149, 2150-2151, 2152-2153, 2154-2155, 2156-2157, 2158-2159, 2160-2161, 2162-2163, 2164-2165, 2166-2167, 2168-2169, 2170-2171, 2172-2173, 2174-2175, 2176-2177, 2178-2179, 2180-2181, 2182-2183, 2184-2185, 2186-2187, 2188-2189, 2190-2191, 2192-2193, 2194-2195, 2196-2197, 2198-2199, 2200-2201, 2202-2203, 2204-2205, 2206-2207, 2208-2209, 2210-2211, 2212-2213, 2214-2215, 2216-2217, 2218-2219, 2220-2221, 2222-2223, 2224-2225, 2226-2227, 2228-2229, 2230-2231, 2232-2233, 2234-2235, 2236-2237, 2238-2239, 2240-2241, 2242-2243, 2244-2245, 2246-2247, 2248-2249, 2250-2251, 2252-2253, 2254-2255, 2256-2257, 2258-2259, 2260-2261, 2262-2263, 2264-2265, 2266-2267, 2268-2269, 2270-2271, 2272-2273, 2274-2275, 2276-2277, 2278-2279, 2280-2281, 2282-2283, 2284-2285, 2286-2287, 2288-2289, 2290-2291, 2292-2293, 2294-2295, 2296-2297, 2298-2299, 2300-2301, 2302-2303, 2304-2305, 2306-2307, 2308-2309, 2310-2311, 2312-2313, 2314-2315, 2316-2317, 2318-2319, 2320-2321, 2322-2323, 2324-2325, 2326-2327, 2328-2329, 2330-2331, 2332-2333, 2334-2335, 2336-2337, 2338-2339, 2340-2341, 2342-2343, 2344-2345, 2346-2347, 2348-2349, 2350-2351, 2352-2353, 2354-2355, 2356-2357, 2358-2359, 2360-2361, 2362-2363, 2364-2365, 2366-2367, 2368-2369, 2370-2371, 2372-2373, 2374-2375, 2376-2377, 2378-2379, 2380-2381, 2382-2383, 2384-2385, 2386-2387, 2388-2389, 2390-2391, 2392-2393, 2394-2395, 2396-2397, 2398-2399, 2400-2401, 2402-2403, 2404-2405, 2406-2407, 2408-2409, 2410-2411, 2412-2413, 2414-2415, 2416-2417, 2418-2419, 2420-2421, 2422-2423, 2424-2425, 2426-2427, 2428-2429, 2430-2431, 2432-2433, 2434-2435, 2436-2437, 2438-2439, 2440-2441, 2442-2443, 2444-2445, 2446-2447, 2448-2449, 2450-2451, 2452-2453, 2454-2455, 2456-2457, 2458-2459, 2460-2461, 2462-2463, 2464-2465, 2466-2467, 2468-2469, 2470-2471, 2472-2473, 2474-2475, 2476-2477, 2478-2479, 2480-2481, 2482-2483, 2484-2485, 2486-2487, 2488-2489, 2490-2491, 2492-2493, 2494-2495, 2496-2497, 2498-2499, 2500-2501, 2502-2503, 2504-2505, 2506-2507, 2508-2509, 2510-2511, 2512-2513, 2514-2515, 2516-2517, 2518-2519, 2520-2521, 2522-2523, 2524-2525, 2526-2527, 2528-2529, 2530-2531, 2532-2533, 2534-2535, 2536-2537, 2538-2539, 2540-2541, 2542-2543, 2544-2545, 2546-2547, 2548-2549, 2550-2551, 2552-2553, 2554-2555, 2556-2557, 2558-2559, 2560-2561, 2562-2563, 2564-2565, 2566-2567, 2568-2569, 2570-2571, 2572-2573, 2574-2575, 2576-2577, 2578-2579, 2580-2581, 2582-2583, 2584-2585, 2586-2587, 2588-2589, 2590-2591, 2592-2593, 2594-2595, 2596-2597, 2598-2599, 2600-2601, 2602-2603, 2604-2605, 2606-2607, 2608-2609, 2610-2611, 2612-2613, 2614-2615, 2616-2617, 2618-2619, 2620-2621, 2622-2623, 2624-2625, 2626-2627, 2628-2629, 2630-2631, 2632-2633, 2634-2635, 2636-2637, 2638-2639, 2640-2641, 2642-

00-06528

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove subsections 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                 |  |  |                                                                                                                                             |  |  |                                                                                                                                                            |  |  |                                                                                                                               | REG. NO. 86 14095                               |                                                                  |                                                                     |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John</b>                                                                                                                                                                                                                                                                                                                                   |  |  | FIRST<br><b>ROYAL JR.</b>                                                                                                                   |  |  | LAST<br><b>ROYAL JR.</b>                                                                                                                                   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 9, 1986</b>                                                                     |                                                 | 2b. HOUR<br><b>1:15 P.M.</b>                                     |                                                                     |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                 |  |  | 4. RACE<br><b>Black</b>                                                                                                                     |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 4 08</b>                                                                                                        |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b>                                                                                   |                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |                                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>                                                                                                                                                                                                                                                                                                                   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                             |                                                 |                                                                  |                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                        |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>                                                                         |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth Steel</b>                                                                        |                                                 |                                                                  |                                                                     |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                        |  |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                             |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                      |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |                                                 |                                                                  | 13e. STREET ADDRESS / ZIP CODE<br><b>2554 Aisquith Street 21218</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Royal</b>                                                                                                                                                                                                                                                                                                                          |  |  |                                                                                                                                             |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Connie Rorie</b>                                                                                       |  |  |                                                                                                                               |                                                 |                                                                  |                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                    |  |  | 16b. SOCIAL SECURITY NO.<br><b>244-36-6748</b>                                                                                              |  |  | 17. INFORMANT<br>ADDRESS<br><b>Ethel Royal 2554 Aisquith Street</b>                                                                                        |  |  |                                                                                                                               |                                                 |                                                                  |                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypotension &amp; liver necrosis and Renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Possible Sepsis - Unknown Source</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes, Hypertension, A&amp;D, Multiple CVA's, Dementia</b> |  |  |                                                                                                                                             |  |  |                                                                                                                                                            |  |  |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                                                                  |                                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a                                                                                                                                                                                                                                                   |  |  |                                                                                                                                             |  |  |                                                                                                                                                            |  |  |                                                                                                                               |                                                 |                                                                  |                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                               |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                  |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                 |                                                                  |                                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                             |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                           |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                              |  |  |                                                                                                                               |                                                 |                                                                  |                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                            |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |  |                                                                                                                               |                                                 |                                                                  |                                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-28</b> , 19 <b>86</b> , to <b>5-9</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5-9</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |  |                                                                                                                                             |  |  |                                                                                                                                                            |  |  |                                                                                                                               |                                                 |                                                                  |                                                                     |  |
| 22b. SIGNATURE<br><b>Carla Sperling M.D.</b>                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                                                             |  |  | DEGREE<br><b>MD</b>                                                                                                                                        |  |  | 22c. DATE SIGNED<br><b>5/9/86</b>                                                                                             |                                                 |                                                                  |                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARL SPERLING, MD.</b>                                                                                                                                                                                                                                                                                                                   |  |  |                                                                                                                                             |  |  | 22e. ADDRESS<br><b>302 E. 33RD ST. BALTO. MD 21218</b>                                                                                                     |  |  |                                                                                                                               |                                                 |                                                                  |                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                        |  |  | 23b. DATE<br><b>5/15/86</b>                                                                                                                 |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md Nat'l Mem Pk.</b>                                                                                              |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel, Md.</b>                                                              |                                                 |                                                                  |                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>March Funeral Homes 1101 East North Avenue</b>                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                                                             |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 14 1986</b>                                                                                                        |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>                                                                            |                                                 |                                                                  |                                                                     |  |

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |                                                                               |                                                                                                                                                             |                                                                                                                                                         |                                                                                         |                                                                                                 |                                                                                                                            |                                                      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CHARLES MARION RHODES, SR.                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 8, 1986                            |                                                                                                                                                             | 2b. HOUR<br>4:41 A.M.                                                                                                                                   |                                                                                         |                                                                                                 |                                                                                                                            |                                                      |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>White                                                                                                                        |                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 23, 1927                                                                                                        |                                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.                                              |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  |                                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                              |                                                                                                 |                                                                                                                            |                                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                                               |                                                                                                                                                             |                                                                                                                                                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Grocery Store Owner |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                      |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         | 13b. COUNTY<br>Q.A.                                                           |                                                                                                                                                             | 13c. CITY OR TOWN<br>Church Hill                                                                                                                        |                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br>Rt. 1 Box 42 21623 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry b. Rhodes                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Ross                   |                                                                                                                                                             |                                                                                                                                                         |                                                                                         |                                                                                                 |                                                                                                                            |                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W.II 220-26-3738 |                                                                                                                                                             | 17. INFORMANT<br>Mary T. Rhodes                                                                                                                         |                                                                                         | ADDRESS<br>same as above                                                                        |                                                                                                                            |                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASYSTOLE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>RENAL FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>PULMONARY EDEMA</u> |  |                                                                                                                                         |                                                                               |                                                                                                                                                             |                                                                                                                                                         |                                                                                         |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 MIN.<br>2 WEEKS<br>5 DAYS                                                |                                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>SEIZURES, FEVER, ACUTE MYELOCYTIC LEUKEMIA</u>                                                                                                                                                                                              |  |                                                                                                                                         |                                                                               |                                                                                                                                                             |                                                                                                                                                         |                                                                                         |                                                                                                 |                                                                                                                            |                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |                                                                                                                                                             |                                                                                                                                                         | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                        |  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |                                                                                                                                                             |                                                                                                                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |                                                                                                 |                                                                                                                            |                                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                    |  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |                                                                                                                                                             |                                                                                                                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |                                                                                                 |                                                                                                                            |                                                      |  |
| 22a. I certify that (this hospital) attended the deceased from <u>APRIL 1</u> , 19 <u>86</u> , to <u>MAY 8</u> , 19 <u>86</u> , that I (we) lost <u>know the deceased alive on MAY 8, 19 86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)                               |  |                                                                                                                                         |                                                                               |                                                                                                                                                             |                                                                                                                                                         |                                                                                         |                                                                                                 |                                                                                                                            |                                                      |  |
| 22b. SIGNATURE<br><u>John Sotos</u>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         |                                                                               |                                                                                                                                                             | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                         | 22c. DATE SIGNED<br>MAY 8, 1986                                                                 |                                                                                                                            |                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John Sotos                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         |                                                                               |                                                                                                                                                             | 22e. ADDRESS<br>Johns Hopkins Hospital 600 N. WOLFE STREET BALTO., MD 21205                                                                             |                                                                                         |                                                                                                 |                                                                                                                            |                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         | 23b. DATE<br>05-12-86                                                         |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Church Hill Cemetery                                                                                              |                                                                                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Church Hill Q.A. MD                               |                                                                                                                            |                                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Tom Helfenbein Funeral Home, Church Hill, MD                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         |                                                                               |                                                                                                                                                             | ADDRESS<br>21623                                                                                                                                        |                                                                                         | 25a. DATE SIGNED BY REGISTRAR<br>MAY 12 1986                                                    |                                                                                                                            |                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |                                                                               |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                                                        |                                                                                         |                                                                                                 |                                                                                                                            |                                                      |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low required by the State of Maryland is that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate and return it to the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 86 14097

|                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                        |  |                                                                                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES D. RUBELING, SR.                                                                                                                                                                                                                                                                                                                           |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5/10/86                         |  | 2b. HOUR<br>7:35 P.M.                                                                                                                                       |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>WHITE                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 12 18                                                                                                               |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.                                                                                                                                                                                                                                                                                                                                              |  | 7. CITIZEN OF WHAT COUNTRY?<br>USA                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                    |  | 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LOCH RAVEN VA HOSP.                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CHAUFFEUR                                                                                                                                                                                                                                                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MEAT PACKER                       |  | 13. STREET ADDRESS / ZIP CODE<br>2707 FAIR AV. / 21224                                                                                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>DAVID RUBELING                                                                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARIE BROWN           |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES                                                                                 |  |
| 16b. SOCIAL SECURITY NO.<br>213-05-6561                                                                                                                                                                                                                                                                                                                                                 |  | 17. INFORMANT<br>B. ARISTIMUNDO                                        |  | ADDRESS<br>MD. 20CH RAVEN VA HOSP.                                                                                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ALCOHOLIC LIVER DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                        |  |                                                                                                                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>INTRACRANIAL BLEED</u>                                                                                                                                                                                                                              |  |                                                                        |  |                                                                                                                                                             |  |
| 19a. DATE OF OPERATION<br>—                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—                  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 16, 1986</u> to <u>MAY 10, 1986</u> , that (I) (we) lost saw the deceased alive on <u>MAY 10, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                           |  |                                                                        |  |                                                                                                                                                             |  |
| 22b. SIGNATURE<br>B. Aristimundo MD                                                                                                                                                                                                                                                                                                                                                     |  | DEGREE<br>MD                                                           |  | 22c. DATE SIGNED<br>5/11/86                                                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>B. ARISTIMUNDO                                                                                                                                                                                                                                                                                                                                 |  | 22e. ADDRESS<br>LOCH RAVEN VA HOSP.                                    |  |                                                                                                                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br>5-14-86                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN CEMETERY                                                                                                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE BALTIMORE MD.                                                                                                                                                                                                                                                                                                                   |  | 23e. DATE REC'D. BY REGISTRAR<br>MAY 14 1986                           |  | 23f. REGISTRAR'S SIGNATURE<br>Julia Davidson                                                                                                                |  |
| 24. FUNERAL DIRECTOR<br>ANN S. MATTHEWS, MATTHEWS FUNERAL HOME<br>3021 EASTERN AVE., BALTIMORE, MD.                                                                                                                                                                                                                                                                                     |  |                                                                        |  |                                                                                                                                                             |  |



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STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                             |                                                                                                                                                                   |                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Dorothy S. S. Rudick</b><br><b>DOROTHY S. S. RUDICK</b>                                                                                                                                                                                                                                                             |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 30 86</b><br>2b. HOUR<br><b>3:30 P.M.</b>                                                                             |                                                                                                                            |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br><b>White</b>                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 12, 1909</b>                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b><br>YRS. MONTHS DAYS HOURS MIN.                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                          |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |                                                                                                                                                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                       |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                                                                                                                                                                                                                                                          |                                                                                                                                             |                                                                                                                                                                   |                                                                                                                            |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                 | 13b. CITY OR TOWN<br><b>Baltimore</b>                                                                                                       | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                   | 13e. STREET ADDRESS / ZIP CODE<br><b>1205 Limekiln Road 21204</b>                                                          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edgar Bowman</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maude Brown</b>                                                                                               |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-01-4167D</b>                                                              | 17. INFORMANT ADDRESS<br><b>Dea L. Downey, Same As #13e 21204</b>                                                                                                 |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>MYOCARDIAL INFARCTION</b><br>(c) <b>CARDIOGENIC SHOCK.</b> |                                                                                                                                             |                                                                                                                                                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a                                                                                                                                                                                                                            |                                                                                                                                             |                                                                                                                                                                   |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                     |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM ETC.)                                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                 |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/22</b> , 19 <b>86</b> , to <b>5/30</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/29</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.    |                                                                                                                                             |                                                                                                                                                                   |                                                                                                                            |
| 22b. SIGNATURE<br><b>L. I. KITCHIN</b>                                                                                                                                                                                                                                                                                                                        |                                                                                                                                             | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>5/30/86</b>                                                                                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. I. KITCHIN</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                             | 22e. ADDRESS<br><b>201 W. UNIVERSITY PARKWAY</b>                                                                                                                  |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                    | 23b. DATE<br><b>6-2-86</b>                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem, Gards. Cockeysville, Balto Md</b>                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>                                                                                                                                                                                                                                                 |                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 3 1986</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Gene Davidson</b>                                                          |                                                                                                                            |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.)

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate must have carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                |  | 2a. DATE OF DEATH                                                                                      |  |                                                                                                                                                             |  | 2b. HOUR                                                            |  |                                                                |  |                                              |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                      |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                      |  | LAST                                                                |  | MONTH DAY YEAR                                                 |  | HOURS MIN.                                   |  |
| CHARLOTTE                                                                                                                                                                                                                                                                                                                                             |  | B.                                                                                                     |  | RUDIN                                                                                                                                                       |  |                                                                     |  | MAY 22, 1986                                                   |  | 6 A.M.                                       |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                                                |  | IF UNDER 24 HRS                              |  |
| FEMALE                                                                                                                                                                                                                                                                                                                                                |  | WHITE                                                                                                  |  | NOV. 22, 1923                                                                                                                                               |  | 62                                                                  |  | MONTHS DAYS                                                    |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                                                |  |                                              |  |
| AUSTRIA                                                                                                                                                                                                                                                                                                                                               |  | USA                                                                                                    |  |                                                                                                                                                             |  | BALTIMORE CITY MD.                                                  |  |                                                                |  |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                             |  |                                                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                             |  | 2132 WESTERN RUN DR.                                                                                   |  |                                                                                                                                                             |  |                                                                     |  | TEACHER                                                        |  | EDUCATION                                    |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS / ZIP CODE                                 |  |                                              |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | BALTIMORE                                                                                                                                                   |  | XX YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 2132 WESTERN RUN DR. 21209                                     |  |                                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                    |  |                                                                     |  |                                                                |  |                                              |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | FIRST MIDDLE LAST                                                                                                                                           |  |                                                                     |  |                                                                |  |                                              |  |
| MAX BICKEL                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | CZARNA GLATTSTEIN                                                                                                                                           |  |                                                                     |  |                                                                |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> OR UNKNOWN <input type="checkbox"/> )                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT                                                                                                                                               |  | ADDRESS                                                             |  |                                                                |  |                                              |  |
| NO                                                                                                                                                                                                                                                                                                                                                    |  | 099-18-0593                                                                                            |  | DR. LOUIS N. RUDIN                                                                                                                                          |  | 2132 WESTERN RUN DR. BALTO., MD 21209                               |  |                                                                |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1 DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u>                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Renal Failure</u>                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| <u>Metastatic Breast Cancer</u>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| (c)                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                             |  | 20a. AUTOPSY?                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                     |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED                                                                                                                                    |  | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |                                                                |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                       |  | HOUR A.M. MONTH DAY YEAR                                                                               |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                       |  | P.M. 19                                                                                                |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY                                                                                   |  | 21f. LOCATION                                                                                                                                               |  |                                                                     |  |                                                                |  |                                              |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                     |  | [AT HOME STREET, FACTORY, OFFICE, FARM, ETC.]                                                          |  | STREET                                                                                                                                                      |  | CITY OR TOWN                                                        |  | COUNTY                                                         |  | STATE                                        |  |
| 22. I certify that (1) (this hospital) attended the deceased from <u>July 1979</u> , to <u>5/22</u> , 19 <u>86</u> , that (1) (we) lost saw the deceased alive on <u>5/19</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                |  |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                             |  | DEGREE                                                              |  | 22c. DATE SIGNED                                               |  |                                              |  |
| <u>John Fetting</u>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |  | 5/22/86.                                                       |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                             |  | 22e. ADDRESS                                                        |  |                                                                |  |                                              |  |
| JOHN FETTING, M.D.                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                             |  | JOHNS HOPKINS HOSP. - BALTO., MD 21205                              |  |                                                                |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                             |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION                                                       |  |                                                                |  |                                              |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                |  | MAY 22, 1986                                                                                           |  | BETH TFILOH                                                                                                                                                 |  | BALTIMORE                                                           |  | COUNTY                                                         |  | MARYLAND                                     |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                     |  |                                              |  |
| NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                             |  | MAY 23 1986                                                         |  | <u>John Davidson</u>                                           |  |                                              |  |

10

00-06105

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14100

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                     |         |                                                                                                                                    |  |                                                                                                                                                                                                                           |  |                                                                     |  |                                                 |  |                                |  |          |  |
|-------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|-------------------------------------------------|--|--------------------------------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                 |         | FIRST                                                                                                                              |  | MIDDLE                                                                                                                                                                                                                    |  | LAST                                                                |  | 2a. DATE KNOWN OF<br>DEATH MATED                |  | MONTH DAY YEAR                 |  | 2b. HOUR |  |
| BETTE Marie RUFF                                                                                                                    |         |                                                                                                                                    |  |                                                                                                                                                                                                                           |  |                                                                     |  | 5-6-86                                          |  | 19                             |  | M        |  |
| 3. SEX                                                                                                                              | 4. RACE | 5. DATE OF BIRTH                                                                                                                   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)                                                                                                                                                                                        |  | IF UNDER 1 YR.                                                      |  | IF UNDER 24 HRS.                                |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | 2d. HOUR |  |
| Female                                                                                                                              | White   | Oct. 19, 1934                                                                                                                      |  | 51 YRS.                                                                                                                                                                                                                   |  |                                                                     |  |                                                 |  | 5-6-86                         |  | 9:05P    |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                        |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                                 |  |                                |  |          |  |
| Maryland                                                                                                                            |         | USA                                                                                                                                |  |                                                                                                                                                                                                                           |  | Baltimore City                                                      |  |                                                 |  |                                |  |          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                           |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                                                                                                                                          |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |                                                 |  |                                |  |          |  |
| Baltimore                                                                                                                           |         | Maryland General Hospital Balto.                                                                                                   |  | Housewife                                                                                                                                                                                                                 |  |                                                                     |  |                                                 |  |                                |  |          |  |
| 13a. STATE                                                                                                                          |         | 13b. COUNTY                                                                                                                        |  | 13c. CITY OR TOWN                                                                                                                                                                                                         |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                             |  | 21230                          |  |          |  |
| Maryland                                                                                                                            |         |                                                                                                                                    |  | Baltimore                                                                                                                                                                                                                 |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1725 Covington St. Balto. Md                    |  |                                |  |          |  |
| 14. FATHER'S NAME                                                                                                                   |         | 15. MOTHER'S MAIDEN NAME                                                                                                           |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.                                            |  | 17. INFORMANT                                   |  | ADDRESS                        |  |          |  |
| Issac                                                                                                                               |         | Bessie                                                                                                                             |  | No                                                                                                                                                                                                                        |  | 214-30-3528                                                         |  | Mr. Lawrence J. Ruff, Same as above             |  |                                |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:                             |         | IMMEDIATE CAUSE (a). Arteriosclerotic cardiovascular disease                                                                       |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                            |  |                                                                     |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                                |  |          |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.                            |         | (b).                                                                                                                               |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                            |  |                                                                     |  |                                                 |  |                                |  |          |  |
| (c).                                                                                                                                |         |                                                                                                                                    |  |                                                                                                                                                                                                                           |  |                                                                     |  |                                                 |  |                                |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |         | sepsis renal insufficiency                                                                                                         |  |                                                                                                                                                                                                                           |  |                                                                     |  |                                                 |  |                                |  |          |  |
| 19a. DATE OF OPERATION                                                                                                              |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                  |  | 20. AUTOPSY?                                                                                                                                                                                                              |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                 |  |                                |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH           |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                                                                             |  |                                                                     |  |                                                 |  |                                |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                        |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                                                                     |  | 21f. LOCATION<br>STREET                                                                                                                                                                                                   |  | CITY OR TOWN                                                        |  | COUNTY                                          |  | STATE                          |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on                                                           |         | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  | death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                     |  |                                                 |  |                                |  |          |  |
| ACTUAL<br>SIGNATURE                                                                                                                 |         | TITLE (SPECIFY)<br>M.D.                                                                                                            |  | MEDICAL EXAMINER                                                                                                                                                                                                          |  | DATE 5-7-86<br>SIGNED                                               |  |                                                 |  |                                |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                  |         | Dennis F. Smyth, M.D.                                                                                                              |  | ADDRESS                                                                                                                                                                                                                   |  | 111 Penn Street                                                     |  |                                                 |  |                                |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                        |         | 23b. DATE                                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                        |  | 23d. LOCATION                                                       |  | COUNTY                                          |  | STATE                          |  |          |  |
| Burial                                                                                                                              |         | 5/10/1986                                                                                                                          |  | Cedar Hill Cemt.                                                                                                                                                                                                          |  | Baltimore A.A. Co. Md.                                              |  |                                                 |  |                                |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                        |         | Balto. Md. 21230                                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE                                          |  |                                                 |  |                                |  |          |  |
| McCully Funeral Home, 130 E. Fort Ave.                                                                                              |         |                                                                                                                                    |  | MAY 9 1986                                                                                                                                                                                                                |  | John Anderson, Wendell                                              |  |                                                 |  |                                |  |          |  |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

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|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                      |                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                               |                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Paul Joseph Russell</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>May 8 1986</b> |                                                                                                                                                             | 2b. HOUR<br><b>4 P.M.</b>                                                            |                                                                                                 |                                                                                                                               |                                                                    |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>White</b>                                                                                                                              |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>7 16</b>                                                                                                              |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                               |                                                                                                                               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, MD</b>                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                           |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City Baltimore City MD.</b>                          |                                                                                                                               |                                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key Medical Center</b> |                                                       |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |                                                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Kennecott Copper</b>       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Dundalk</b>                                                                                                                                                                                  |  |                                                                                                                                                      |                                                       |                                                                                                                                                             |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                               | 13e. STREET ADDRESS / ZIP CODE<br><b>1762 Melbourne Road 21222</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Peter Paul Russell</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                      |                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Zukowski</b>                                                                                  |                                                                                      |                                                                                                 |                                                                                                                               |                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W. 2 216-10-7589</b>                                                                 |                                                       | 17. INFORMANT ADDRESS<br><b>Nancy Robertson 1762 Melbourne Rd. 21222</b>                                                                                    |                                                                                      |                                                                                                 |                                                                                                                               |                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>hypoxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>chronic obstructive pulmonary disease</b>                                                       |  |                                                                                                                                                      |                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>                                                                                                                                                                                                                            |  |                                                                                                                                                      |                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                               |                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |                                                       |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                    |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |                                                                                      |                                                                                                 |                                                                                                                               |                                                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                                 |                                                                                                                               |                                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 1</b> , 19 <b>86</b> , to <b>May 8</b> , 19 <b>86</b> , tho (I) (we) lost<br>saw the deceased alive on <b>May 8</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) not view the body after death. |  |                                                                                                                                                      |                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                               |                                                                    |  |
| 22b. SIGNATURE<br><b>Ann J. Ma, M.D.</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                      |                                                       | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                      |                                                                                                 |                                                                                                                               | 22c. DATE SIGNED<br><b>5/8/86</b>                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ann J. Ma, M.D.</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                      |                                                       | 22e. ADDRESS<br><b>Francis Scott Key Medical Center 4445 Eastern Ave</b>                                                                                    |                                                                                      |                                                                                                 |                                                                                                                               |                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>5-12-86</b>                                                                                                                          |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                                                                                              |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Eastwood, Balto. Co. Md.</b>                   |                                                                                                                               |                                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Charles S. Zeiler &amp; Son Inc.</b> ADDRESS <b>6224 Eastern Ave.</b>                                                                                                                                                                                                                                                                |  |                                                                                                                                                      |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 12 1986</b>                                                                                                         |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                |                                                                                                                               |                                                                    |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8614102  
REG. NO.1 - FOR  
STATE  
REGISTRAR

|                                                                                                                  |  |                                                                                                                                          |                                                                           |                                                                                                                                                             |                                |                                                                                |                                                                                                 |                                                                     |                                                          |  |
|------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>SHIRLEY J RUSSELL                                    |  |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>05 15 86                           |                                                                                                                                                             |                                | 2b. HOUR<br>10:25 AM                                                           |                                                                                                 |                                                                     |                                                          |  |
| 3. SEX<br>FEMALE                                                                                                 |  | 4. RACE<br>BLACK                                                                                                                         |                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 20 42                                                                                                              |                                | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>44 YRS.                                  |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |                                                          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>NORTH CAROLINA                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                      |                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                     |                                                                                                 |                                                                     |                                                          |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BONSECOURS 2000 W. BALTO ST |                                                                           |                                                                                                                                                             |                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DISABILITY |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD |  |                                                                                                                                          | 13b. COUNTY                                                               |                                                                                                                                                             | 13c. CITY OR TOWN<br>BALTIMORE |                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                     | 13e. STREET ADDRESS / ZIP CODE<br>2149 MT HOLLY ST 21216 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JAMES ROBERTSON                                                        |  |                                                                                                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>NANCY WILKESON ROBERTSON |                                                                                                                                                             |                                |                                                                                |                                                                                                 |                                                                     |                                                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                       |  |                                                                                                                                          | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217402633      |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS       |                                                                                |                                                                                                 |                                                                     |                                                          |  |

|                                                                                                                                                                                                                                                             |  |                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Metastatic Carcinoma of Colon<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                          |  |                                                                        |  |                                                                                      |  |                                                                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)       |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from 19 85 to 5/15 19 86, that (I) (we) last saw the deceased alive on 5/10 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                      |  |                                                                                                                               |  |
| 22a. SIGNATURE<br>Harold E. Ramsey, MD                                                                                                                                                                                                                                                                   |  |                                                                        |  | DEGREE<br>MD                                                                         |  | 22c. DATE SIGNED<br>5/15/86                                                                                                   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harold E. Ramsey                                                                                                                                                                                                                                                |  |                                                                        |  | 22e. ADDRESS<br>301 McMECHEN ST. BALTO, MD. 21217                                    |  |                                                                                                                               |  |

|                                                              |  |                      |  |                                                  |  |                                                        |  |
|--------------------------------------------------------------|--|----------------------|--|--------------------------------------------------|--|--------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL       |  | 23b. DATE<br>5/20/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bulto Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto MD |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Jeff Miller Funeral Services |  |                      |  | ADDRESS<br>4611 Park Hgts                        |  | 25. DATE REC'D. BY REGISTRAR<br>MAY 19 1986            |  |
|                                                              |  |                      |  | 26. REGISTRAR'S SIGNATURE                        |  |                                                        |  |

24. FUNERAL DIRECTOR

NAME

ADDRESS

25. DATE REC'D. BY REGISTRAR

26. REGISTRAR'S SIGNATURE

BP \_\_\_\_\_

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

(1)

00-07462

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove chapter 4, page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a death certificate must be filed with the State Dept. of Health and Mental Hygiene.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                 |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                               |  | 8614103                                                                                                                            |  | REG. NO.                                                                                                                                                    |  |                                                                                       |  |                                                                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ANTHONY J RUSSO</b>                                                                                                                                                                                                                                         |  |                                                                                                                                    |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>22 MAY 86</b>                                                                                                        |  | 2b. HOUR<br><b>0905 AM</b>                                                            |  |                                                                                   |  |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>white</b>                                                                                                            |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10/8/22</b>                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>63</b>                                      |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Md.</b>                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY MD.</b>                    |  |                                                                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LOC RAVEN VA HOSP</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self-Employed</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Wholesale Produce</b>                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY<br><b>MD</b>                                                                                                                                                                                                |  | 13c. CITY OR TOWN<br><b>BALT</b>                                                                                                   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |  | 13e. STREET ADDRESS / ZIP CODE<br><b>519 N. PORT STREET 21205</b>                     |  |                                                                                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Russo</b>                                                                                                                                                                                                                                                             |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Josephine Russo</b>                                                                                        |  |                                                                                       |  |                                                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>WW II</b>                                                               |  | 17. INFORMANT ADDRESS<br><b>Barbara Russo, 3915 Shannon Dr. 21213</b>                                                                                       |  |                                                                                       |  |                                                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b>                                                                                                                                                              |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 mins.</b>                    |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>SEVERE MALNUTRITION</b>                                                                                                                                                                                        |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                       |  | <b>~5 yrs.</b>                                                                    |  |
| (c) <b>CHEST SYNDROME</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                       |  | <b>Dxed 1960</b>                                                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1</b>                                                                                                                                                                            |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                   |  |
| 19a. DATE OF OPERATION<br><b>7 MAY 86</b>                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>malnutrition</b>                                                                                     |  |                                                                                       |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                   |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |  |                                                                                       |  |                                                                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                       |  |                                                                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                   |  |
| 22b. SIGNATURE<br><b>ROMANOSKY MD PhD</b>                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  | DEGREE                                                                                                                                                      |  |                                                                                       |  | 22c. DATE SIGNED<br><b>22 MAY 86</b>                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROMANOSKY</b>                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  | 22e. ADDRESS<br><b>Dept Med, LRVA Hosp, BALT MD</b>                                                                                                         |  |                                                                                       |  |                                                                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>5/24/86</b>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>                                                                                                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                         |  |                                                                                   |  |
| 24. FUNERAL HOME (NAME ADDRESS)<br><b>Schmunk Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213</b>                                                                                                                                                                                                             |  |                                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1986</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>                            |  |                                                                                   |  |

BP

0-0113

1944 12 24

1944 12 24

VICTORY

1944 12 24



0-08376

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 1 0 4  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                           |                                                           |                                                                                                                                                             |                                                                                      |                                                                                                                            |                                               |                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|----------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Frances Rutkowski</b>                                                                                                                                                                                                                                                                   |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 27 1986</b> |                                                                                                                                                             | 2b. HOUR<br><b>12:30</b>                                                             |                                                                                                                            |                                               |                                                                |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>White</b>                                                                                                                   |                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 14 1908</b>                                                                                                   |                                                                                      | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>77</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.               |                                               |                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             |                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                          |                                               |                                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3234 Belair Rd. 21213</b> |                                                           |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b> |                                                                |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY<br><b>-</b>                                                                                                                   |                                                           | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                               | 13e. STREET ADDRESS / ZIP CODE<br><b>3234 Belair Rd. 21213</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James P. Egan</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen C. Collins</b>                                                                                    |                                                                                      |                                                                                                                            |                                               |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-05-4990</b>                                                             |                                                           | 17. INFORMANT<br>ADDRESS (dghtr-in-law)<br><b>Charlotte Rutkowski 5602 Cedonia Ave. 21206</b>                                                               |                                                                                      |                                                                                                                            |                                               |                                                                |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                           |                                                           |                                                                                                                                                             |                                                                                      |                                                                                                                            |                                               |                                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>HYPERTENSION; DIABETES MELLITUS</b>                                                                                                                                                                         |  |                                                                                                                                           |                                                           |                                                                                                                                                             |                                                                                      |                                                                                                                            |                                               |                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                               |                                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                |                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                      |                                                                                                                            |                                               |                                                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                                                            |                                               |                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |                                                                                                                                           |                                                           |                                                                                                                                                             |                                                                                      |                                                                                                                            |                                               |                                                                |  |
| 22b. SIGNATURE<br><b>Dr. Gamboa</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |                                                           | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                      | 22c. DATE SIGNED<br><b>5-29-86</b>                                                                                         |                                               |                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Gamboa</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |                                                           | 22e. ADDRESS<br><b>3440 Belair Rd., Baltimore, Md.</b>                                                                                                      |                                                                                      |                                                                                                                            |                                               |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>5/31/86</b>                                                                                                               |                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>                                                                                                  |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                                         |                                               |                                                                |  |
| 24. FUNERAL HOME<br>NAME ADDRESS<br><b>Schumanek Funeral Home, Inc.<br/>3331 Brehms Lane, Balto. Md. 21213</b>                                                                                                                                                                                                                                         |  |                                                                                                                                           |                                                           | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 4 1986</b>                                                                                                          |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Jana W. ...</b>                                                                           |                                               |                                                                |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 701 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



WILSON, J. H.

WILSON, J. H.

WILSON, J. H.

00-06109

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4105

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                                                         |                                                                                              |                                                                                        |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Toivo - Saard</b>                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                         | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>5</b> DAY <b>8</b> YEAR <b>19 86</b> |                                                                                                                                                             |                                                                                                         | 2b. HOUR <b>6:48</b> AM                                                                      |                                                                                        |                                              |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>June</b> DAY <b>11</b> YEAR <b>1910</b>                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.                                                         | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>                                                                                                             | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                                                        | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>5</b> DAY <b>8</b> YEAR <b>19 86</b>                    |                                                                                        |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Estonia</b>                                                                                                                                                                                                                                                                                                                                                                           |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                              |                                                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |                                                                                        |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                         |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Key Medical Center</b> |                                                                                                           |                                                                                                                                                             |                                                                                                         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b>             |                                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY            |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                                                         |                                                                                              |                                                                                        |                                              |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 13b. COUNTY                                                                                                                             |                                                                                                           | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                                                         | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                        |                                              |
| 14. FATHER'S NAME<br>FIRST <b>-</b> MIDDLE <b>-</b> LAST <b>Saard</b>                                                                                                                                                                                                                                                                                                                                                                 |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>-</b> MIDDLE <b>-</b> LAST <b>-</b>                                                                |                                                                                                           |                                                                                                                                                             |                                                                                                         |                                                                                              |                                                                                        |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                                      |                         | (IF YES, GIVE YEAR OR DATES)<br><b>WW 2</b>                                                                                             |                                                                                                           | 16b. SOCIAL SECURITY NO.<br><b>214-18-0118</b>                                                                                                              |                                                                                                         | 17. INFORMANT ADDRESS<br><b>Mrs. Dorothy M. Saard Same</b>                                   |                                                                                        |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound to head (handgun)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                 |                         |                                                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                                                         |                                                                                              |                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                                                         |                                                                                              |                                                                                        |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                         |                                                                                                                                                             |                                                                                                         |                                                                                              | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5:30 PM 5-8- 1986</b>                               |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Self-inflicted.</b> |                                                                                              |                                                                                        |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>                                |                                                                                                                                                             | 21f. LOCATION<br>CITY OR TOWN <b>4312 LaSalle Ave., Balto.</b> COUNTY <b>BALTO.</b> STATE <b>MD</b>     |                                                                                              |                                                                                        |                                              |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                         |                                                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                                                         |                                                                                              |                                                                                        |                                              |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                         | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER                                                 |                                                                                                                                                             |                                                                                                         | DATE SIGNED <b>5-8-86</b>                                                                    |                                                                                        |                                              |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                         | ADDRESS<br><b>111 Penn St., Balto., MD 21201</b>                                                          |                                                                                                                                                             |                                                                                                         |                                                                                              |                                                                                        |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                         | 23b. DATE<br><b>May 9, 1986</b>                                                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial</b>                                          |                                                                                              | 23d. LOCATION<br>CITY OR TOWN <b>Catonsville</b> COUNTY <b>BALTO.</b> STATE <b>MD.</b> |                                              |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                         |                                                                                                           |                                                                                                                                                             | 25a. DATE RECEIVED BY REGISTRAR <b>MAY 9 1986</b> 25b. REGISTRAR'S SIGNATURE                            |                                                                                              |                                                                                        |                                              |

THE UNIVERSITY OF CHICAGO  
LIBRARY

June 11, 1919

Madam

Dear Sir

Very respectfully

Yours truly

Wm. L. Garrison

11-1-1919

Yours

Wm. L. Garrison, Secretary  
June 11, 1919  
University of Chicago Library

00-05604

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 1 0 6  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BETTY RUTH SACKS</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 02 1986</b>                                                                              |  | 2b. HOUR<br><b>6:7p</b> M                                                                                                                                   |                                                                                                     |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>WHITE</b>                                                                                                                |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 2 20</b>                                                                                                         |                                                                                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                     |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                                                                            |                                                                                                     |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                                                                                                                                                                                                                                                                                                                                                          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Drug Store</b>                                                                                 |  |                                                                                                                                                             |                                                                                                     |
| 13a. STREET ADDRESS / ZIP CODE<br><b>5701 First Avenue 21227</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 13b. CITY OR TOWN<br><b>Halethorpe</b>                                                                                                 |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |                                                                                                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Brockunier</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cora Follmar</b>                                                                   |  |                                                                                                                                                             |                                                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br><b>172-18-9016</b>                                                                                         |  | 17. INFORMANT<br>ADDRESS<br><b>Lester F. Sacks 5701 First Avenue 21227</b>                                                                                  |                                                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MASSIVE ASPIRATION OF BLOOD</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>RUPTURED THORACIC AORTIC ANEURYSM INTO THE ESOPHAGUS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEVERE ATHEROSCLEROSIS</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                        |  |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>AT DEATH</b><br><br><b>"</b><br><br><b>YEARS</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  | 20a. AUTOPSY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                         |                                                                                                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                                                     |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-27</b> , 19 <b>86</b> , to <b>5-2</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5-2</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                          |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                                                     |
| 22b. SIGNATURE<br><b>James E. Taylor</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | DEGREE<br><b>M.D.</b>                                                                                                                  |  | 22c. DATE SIGNED<br><b>5/3/86</b>                                                                                                                           |                                                                                                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES E. TAYLOR, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL</b>                                                                                              |  |                                                                                                                                                             |                                                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>5/6/86</b>                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk.</b>                                                                                            |                                                                                                     |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>                                      |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 5 1986</b>                                                                                                          |                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 25b. REGISTRAR'S SIGNATURE<br><b>James E. Taylor</b>                                                                                   |  |                                                                                                                                                             |                                                                                                     |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 1 0 7  
REG. NO.

|                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                         |                                                     |                                                                                                                                                                      |                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MANUEL SAMPEDRO SR                                                                                                                                                                                                                          |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 14, 1986 |                                                                                                                                                                      | 2b. HOUR<br>10:09AM |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>White                                                                                                                        |                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 28 1935                                                                                                                 |                     |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS.                                                                                                                                                                                                                                                              |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Spain                                                                                       |                                                     | 8. CITIZEN OF WHAT COUNTRY?<br>Spain                                                                                                                                 |                     |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD.                                                                                                                                                                                                                                                   |  | 10. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Master Taylor                                                        |                                                     | 11. KIND OF BUSINESS OR INDUSTRY<br>Corvette                                                                                                                         |                     |  |
| 12. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                     | 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE Maryland 15b. COUNTY BALTIMORE 15c. CITY OR TOWN Baltimore |                     |  |
| 16. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Fidel Sampedro                                                                                                                                                                                                                                                |  | 17. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Manuela Rey                                                                            |                                                     | 18. ADDRESS<br>21237 Dolores Sampedro 9401 Armada Way                                                                                                                |                     |  |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                               |  | 20. SOCIAL SECURITY NO.<br>137 48 3046                                                                                                  |                                                     | 21. INFORMANT<br>Dolores Sampedro                                                                                                                                    |                     |  |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ANOXIC ENCEPHALOPATHY<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) UPPER AIRWAY OBSTRUCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ACUTE MYELOMONOCYTIC LEUKEMIA          |  | 23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>13 DAYS<br>13 DAYS<br>18 MONTHS                                                     |                                                     |                                                                                                                                                                      |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>ASPERGILLUS SMALL BOWEL OBSTRUCTION SUPERIOR VENA CAVA SYNDROME                                                                                                 |  |                                                                                                                                         |                                                     |                                                                                                                                                                      |                     |  |
| 24. DATE OF OPERATION                                                                                                                                                                                                                                                                                   |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |                                                     | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                  |                     |  |
| 27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                    |  | 28. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |                                                     | 29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                        |                     |  |
| 30. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                |  | 31. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |                                                     | 32. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                     |                     |  |
| 33. I certify that (I) this hospital attended the deceased from 3/5, 1986, to 5/14, 1986, that (I) (we) last saw the deceased alive on 5/14, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |                                                                                                                                         |                                                     |                                                                                                                                                                      |                     |  |
| 34. SIGNATURE<br>John G. Sotos                                                                                                                                                                                                                                                                          |  | 35. DEGREE<br>MD                                                                                                                        |                                                     | 36. DATE SIGNED<br>5/14/86                                                                                                                                           |                     |  |
| 37. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John G. Sotos                                                                                                                                                                                                                                                   |  | 38. ADDRESS<br>Johns Hopkins Hospital                                                                                                   |                                                     |                                                                                                                                                                      |                     |  |
| 39. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                   |  | 40. DATE<br>May 17 '86                                                                                                                  |                                                     | 41. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart of Mary                                                                                                            |                     |  |
| 42. FUNERAL DIRECTOR<br>NAME<br>Lilly & Zeiler, Inc.                                                                                                                                                                                                                                                    |  | 43. ADDRESS<br>21231 1901 Eastern Ave.                                                                                                  |                                                     | 44. DATE REC'D. BY REGISTRAR<br>MAY 16 1986                                                                                                                          |                     |  |
| 45. REGISTRAR'S SIGNATURE<br>John Davidson                                                                                                                                                                                                                                                              |  | 46. REGISTRAR'S SIGNATURE                                                                                                               |                                                     |                                                                                                                                                                      |                     |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician who examines the body be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician, it should be detached for use on the burial permit. Then please remove the pages with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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00-07518

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/B4  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                             |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                              |                                                                   |                                                                                              |  | 8                                                                                                                       | 6                                                            | 1                                                   | 4 | 1                          | 0 | 8 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------|---|----------------------------|---|---|
| 1. STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                              |                                                                   |                                                                                              |  | REG. NO.                                                                                                                |                                                              |                                                     |   |                            |   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Mildred L. Sann</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                              |                                                                   |                                                                                              |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5-24-86</b>                                                                      |                                                              |                                                     |   | 2b. HOUR<br><b>1:40 PM</b> |   |   |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>White</b>                                                                                                                  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8-1-1920</b>                                                                                                          |  |                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS                  |                                                                                              |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                             |                                                              | IF UNDER 72 HRS. HOURS MIN.                         |   |                            |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |                                                                                              |  |                                                                                                                         |                                                              |                                                     |   |                            |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANCIS SCOTT KEY M. C.</b> |  |                                                                                                                                                             |  |                                                              |                                                                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SEAMSTRESS</b>           |  |                                                                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>LONDON TOWN MAN.</b> |                                                     |   |                            |   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                  |  |                                                                                                                                          |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                             |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                        |                                                                   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3709 E. Lombard St. 21224</b>                                                      |                                                              |                                                     |   |                            |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>CLAYTON</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>McBRIDE VIRGINIA UNK.</b>                                                                                  |  |                                                              |                                                                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>               |  |                                                                                                                         |                                                              |                                                     |   |                            |   |   |
| 16b. SOCIAL SECURITY NO.<br><b>217-09-4989</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |  | 17. INFORMANT ADDRESS<br><b>MR. CHARLES J. SANN 3709 E. Lombard St. 21224</b>                                                                               |  |                                                              |                                                                   |                                                                                              |  |                                                                                                                         |                                                              |                                                     |   |                            |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Septic</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Colon carcinoma</b> |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                              |                                                                   |                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                            |                                                              |                                                     |   |                            |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a                                                                                                                                                                                                                                               |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                              |                                                                   |                                                                                              |  |                                                                                                                         |                                                              |                                                     |   |                            |   |   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                              |                                                                   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                              |                                                     |   |                            |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                               |  |                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                              |  |                                                              |                                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |  |                                                                                                                         |                                                              |                                                     |   |                            |   |   |
| 21d. INJURY OCCURRED<br>WOUND <input type="checkbox"/> NOT WOUND <input type="checkbox"/>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |  |                                                              |                                                                   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                         |                                                              |                                                     |   |                            |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/21</b> , 19 <b>86</b> , to <b>5/24</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/24</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                              |                                                                   |                                                                                              |  |                                                                                                                         |                                                              |                                                     |   |                            |   |   |
| 22b. SIGNATURE<br><b>Loa Steen MD</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                              |                                                                   | DEGREE                                                                                       |  | 22c. DATE SIGNED<br><b>5/24/86</b>                                                                                      |                                                              |                                                     |   |                            |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STERN</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                              |                                                                   | 22e. ADDRESS<br><b>4940 Eastern Ave Ball. MD 21224</b>                                       |  |                                                                                                                         |                                                              |                                                     |   |                            |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |  | 23b. DATE<br><b>5-27-86</b>                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAKAWN Cemetery</b> |                                                                   |                                                                                              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore MARYLAND</b>                                                    |                                                              |                                                     |   |                            |   |   |
| 24. FUNERAL DIRECTOR NAME<br><b>Joseph N. ZANNINO Jr.</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                              |                                                                   | ADDRESS<br><b>2635 CONKLINE ST. 21224</b>                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 26 1986</b>                                                                     |                                                              | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b> |   |                            |   |   |

MEDICAL CERTIFICATION



00-07835

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14109  
REG. NO.1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THOMAS SAUNDERS</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |  | 2a. DATE OF DEATH<br>MONTH <b>MAY</b> DAY <b>23</b> YEAR <b>86</b>                                                                                          |  | 2b. HOUR<br><b>400 PM</b>                                                                                                  |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>BLACK</b>                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>19</b> YEAR <b>00</b>                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>So. CAROLINA</b>                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. City</b> MD.                                                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. City</b>                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Hon Secours Hosp.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>                                                                          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Scrap-yard</b>                                                                     |  |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                       |  | 13b. COUNTY<br><b>BALTO</b>                                                                                                                                 |  | 13c. CITY OR TOWN<br><b>BALTO</b>                                                                                          |  |
| 14. FATHER'S NAME<br>FIRST <b>Richard</b> MIDDLE <b>SAUNDERS</b> LAST <b>SAUNDERS</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mamie</b> MIDDLE <b>Merles</b> LAST <b>Merles</b>                                                                      |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br><b>218-10-2843</b>                                                                                                              |  | 17. INFORMANT<br><b>Chart. (Muerie Saunders brother)</b>                                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.              |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                           |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/21</b> 19 <b>86</b> , to <b>5/23</b> 19 <b>86</b> , that (I) (the hospital) saw the deceased alive on <b>5/23</b> 19 <b>86</b> , and that in (my) (the hospital's) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>John Shavers</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  | DEGREE<br><b>PHYSICIAN</b>                                                                                                                                  |  | 22c. DATE SIGNED<br><b>5/23/86</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN SHAVERS</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  | 22e. ADDRESS<br><b>518 CAMP MERRILL RD LINTHicum MD</b>                                                                                                     |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>5/28/86</b>                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Maryland</b>                                                     |  |
| 24. FUNERAL DIRECTOR<br>(NAME)<br><b>Wm C March F/H West</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 28 1986</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>                                                                         |  |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all tabular papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
JAN 11 1953  
U.S. AIR FORCE  
OFFICE OF THE  
JOINT CHIEFS OF STAFF  
WASHINGTON, D.C.

TO: THE SECRETARY OF DEFENSE  
FROM: THE SECRETARY OF THE AIR FORCE  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum format with several paragraphs of text that is mostly illegible due to fading and bleed-through.]

00-06486

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 1 1 0

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                            |                                                                                                                                                             |                                                                                    |                                                                                      |                                                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Owlen C. Scaggs, SR.                                                                                                                                                                                                                                                                                                              |                                                                                                                                            |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5-12-86                                     |                                                                                      | 2b. HOUR<br>7:40 AM                                                                                                                   |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>White                                                                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 3 23                                                                                                               |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.                                           | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                                      |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                 | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                         |                                                                                      |                                                                                                                                       |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hosp. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Brewery Worker | 12b. KIND OF BUSINESS OR INDUSTRY<br>Tuborg Brewery                                  |                                                                                                                                       |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                            |                                                                                                                                                             | 13b. COUNTY                                                                        | 13c. CITY OR TOWN<br>Baltimore                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Jennings Bryant Scaggs                                                                                                                                                                                                                                                                                                 |                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Violet Ivanna Clements                                                                                     |                                                                                    |                                                                                      |                                                                                                                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                              |                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II                                                                                            |                                                                                    | 17. INFORMANT<br>ADDRESS<br>Dolores L. Scaggs, 2617 Northshire Drive                 |                                                                                                                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial infarct</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |                                                                                                                                            |                                                                                                                                                             |                                                                                    |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                   |                                                                                                                                            |                                                                                                                                                             |                                                                                    |                                                                                      |                                                                                                                                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                    | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |                                                                                                                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                                                                      |                                                                                                                                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                           |                                                                                                                                            | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |                                                                                      |                                                                                                                                       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-12-86</u> to <u>5-12-86</u> , that (I) (we) lost saw the deceased alive on <u>5-12-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                             |                                                                                                                                            |                                                                                                                                                             |                                                                                    |                                                                                      |                                                                                                                                       |
| 22b. SIGNATURE<br><u>Martin Guerrero</u> MD                                                                                                                                                                                                                                                                                                                              |                                                                                                                                            | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                    | 22c. DATE SIGNED<br>5-12-86                                                          |                                                                                                                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Martin Guerrero, M.D.                                                                                                                                                                                                                                                                                                           |                                                                                                                                            | 22e. ADDRESS<br>3001 So. Hanover St. Balti., MD 21230                                                                                                       |                                                                                    |                                                                                      |                                                                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                   | 23b. DATE<br>5/15/86                                                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br>Crestlawn Garden of Mem.                                                                                              |                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Marriottsville Howard Md.              |                                                                                                                                       |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.,                                                                                                                                                                                                                                                                                                              |                                                                                                                                            | ADDRESS<br>4107 Wilkens Ave.                                                                                                                                |                                                                                    | 25a. DATE REC'D. BY REGISTRAR<br>MAY 14 1986                                         |                                                                                                                                       |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a duly qualified physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose this permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or transport.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

Col. J. C. ...

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00-07839

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                          |  |                                                                                                                                                            |  |                                                                                      |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                          |  |                                                                                                                                                            |  |                                                                                      |  |                                                                                                                            |  |
| 8 6 1 4 1 1 1                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                          |  |                                                                                                                                                            |  |                                                                                      |  |                                                                                                                            |  |
| 1 - FOR STATE REGISTRAR Elmer Andrew Schafer, Sr. CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                          |  |                                                                                                                                                            |  |                                                                                      |  |                                                                                                                            |  |
| REG. NO.                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                          |  |                                                                                                                                                            |  |                                                                                      |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Elmer Andrew Schafer, Sr.                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                          |  |                                                                                                                                                            |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5/27/86                                          |  | 2b. HOUR<br>5:55 P.M.                                                                                                      |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                             |  | 4 RACE<br>White                                                                                                          |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2/28/1894                                                                                                               |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS<br>92                                             |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                 |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                      |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                    |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                           |  |                                                                                                                            |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |  |                                                                                                                                                            |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Carpenter            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Housing                                                                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland                                                                                                                                                                                                                                                                                          |  |                                                                                                                          |  |                                                                                                                                                            |  | 13b COUNTY<br>Baltimore                                                              |  | 13c CITY OR TOWN<br>Arbutus                                                                                                |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>George Schafer                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                          |  |                                                                                                                                                            |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Annie Baus                              |  |                                                                                                                            |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                    |  | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>214.01.9866A                                                      |  | 17 INFORMANT ADDRESS<br>Elmer A. Schafer, Jr. (same as 13e)                                                                                                |  |                                                                                      |  |                                                                                                                            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>lung Ct</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>&gt; 1 month</u><br><u>&gt; 1 month</u><br><u>&gt; 1 week</u> |  |                                                                                                                          |  |                                                                                                                                                            |  |                                                                                      |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Malnutrition</u>                                                                                                                                                                                                                                                      |  |                                                                                                                          |  |                                                                                                                                                            |  |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                         |  |                                                                                                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                      |  |                                                                                                                            |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>5/2</u> , 19 <u>85</u> to <u>5/27</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/27</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                            |  |                                                                                                                          |  |                                                                                                                                                            |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Joanne Kinney, MD                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                          |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |                                                                                      |  | 22c. DATE SIGNED<br>5/27/86                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joanne Kinney, MD                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                          |  | 22e. ADDRESS<br>Mercy Hospital, 301 St Paul St Bldg 20                                                                                                     |  |                                                                                      |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>5/29/1986                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematory                                                                                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, MD                     |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Brooks Bradley, Inc. Balto., MD 21222                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 28 1986                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br>Joanne Kinney                                          |  |                                                                                                                            |  |



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WILLIAM  
H. HARRIS  
C. J. HARRIS



WILLIAM HARRIS

00-05538

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 1 1 2  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                   |                                                                                                                                            |                                                                                                                                                             |                                                                                                         |                                                                     |                                   |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>LEON J. SCHAFER</b>                      |                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 1, 1986</b>                                                                                                   |                                                                                                         | 2b. HOUR<br>P<br><b>2:45</b> M                                      |                                   |
| 3 SEX<br><b>Male</b>                                                              | 4. RACE<br><b>White</b>                                                                                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 1, 1940</b>                                                                                                   |                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b> YRS.                   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Michigan</b>                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Owner - Sporting Goods Store</b> |                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>Michigan</b>                                                     |                                                                                                                                            | 13b. CITY OR TOWN<br><b>Isabella</b>                                                                                                                        | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         | 13e. STREET ADDRESS / ZIP CODE<br><b>3222 N. Woodruff Rd. 48893</b> |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Andrew Schafer</b>                   |                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Schafer</b>                                                                                        |                                                                                                         |                                                                     |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br><b>366-40-5753</b>                                                                                                              |                                                                                                         | 17. INFORMANT ADDRESS<br><b>Carol J. Schafer - Same as #13e</b>     |                                   |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **cardiorespiratory arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

(b) **sepsis**

DUE TO, OR AS A CONSEQUENCE OF

(c) **hepatoma**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**30 minutes**

**12 hours**

**6 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

**cerebral hematoma**

|                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                |  |                                                                               |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                               |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/26</b> , 19 <b>86</b> , to <b>5/1</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased die on <b>5/1</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death. |  |                                                                                                                                                                |  |                                                                               |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Charles B. Treasure</b>                                                                                                                                                                                                                                                                                                              |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                               |  | 22c. DATE SIGNED<br><b>5/1/86</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles B. Treasure</b>                                                                                                                                                                                                                                                                                       |  | 22e. ADDRESS<br><b>600 N. Wolfe St. Balt, MD 21210</b>                                                                                                         |  |                                                                               |  |                                                                                                                            |  |

|                                                                                                 |  |                            |  |                                                                    |  |                                                                                    |  |
|-------------------------------------------------------------------------------------------------|--|----------------------------|--|--------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                   |  | 23b. DATE<br><b>5-6-86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Joseph's Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Beal City, Isabella, Michigan</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 5 1986</b>                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                   |  |

DDMM - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 48 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or medical examiner, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Please note: This certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

NOTICE TO THE PUBLIC

CHIEF OF POLICE

RECEIVED  
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1 20 205  
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00-09182

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 1 1 3

|                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                |                                                                               |                                                                                                                                                             |                                                                                                    |                                                                                                                                                      |                                                                                                 |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FRANCIS SCHAUBER</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 29, 1986</b>                    |                                                                                                                                                             |                                                                                                    | 2b. HOUR<br><b>9.55 A</b>                                                                                                                            |                                                                                                 |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>White</b>                                                                                                                        |                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jun. 14., 1921</b>                                                                                                 |                                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                                                                                    |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     |                                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                                    |                                                                                                 |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                               |                                                                                                                                                             |                                                                                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Brick Manufacturer</b>                                                        |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                | 13b. COUNTY<br><b>Kent</b>                                                    |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Chestertown</b>                                                            |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>105 Cedar St. 21620</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Schaubert</b>               |                                                                                                                                                             |                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ann Magrogan</b>                                                                            |                                                                                                 |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW 2</b>        |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>105 Cedar St. 21620</b><br><b>Louise Schaubert Chestertown, Md.</b> |                                                                                                                                                      |                                                                                                 |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>idiopathic pericarditis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>sepsis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                                |                                                                               |                                                                                                                                                             |                                                                                                    |                                                                                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 minute</b><br><b>1 week</b>                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):                                                                                                                                                                                                                                                     |  |                                                                                                                                                |                                                                               |                                                                                                                                                             |                                                                                                    |                                                                                                                                                      |                                                                                                 |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>5/6/86</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>pulmonary fibrosis</b> |                                                                                                                                                             |                                                                                                    | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                 |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                |  |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             |                                                                                                                                                             |                                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                                                 |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                             |  |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |                                                                                                                                                             |                                                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                                 |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/6/86</b> , 19 <b>86</b> , to <b>5/29</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/29</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |                                                                                                                                                |                                                                               |                                                                                                                                                             |                                                                                                    |                                                                                                                                                      |                                                                                                 |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Franklin C. Welfald</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                |                                                                               |                                                                                                                                                             |                                                                                                    | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>5/29/86</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Franklin C. Welfald</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                |                                                                               |                                                                                                                                                             |                                                                                                    | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                                                                                                        |                                                                                                 |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                | 23b. DATE<br><b>5/31/1986</b>                                                 |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Hill Catholic</b>                                  |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Church Hill, Md.</b>                           |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J. Willis Wells</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                |                                                                               |                                                                                                                                                             |                                                                                                    | ADDRESS<br><b>Chestertown, Md.</b>                                                                                                                   |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 04 1986</b>                                                                        |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                |                                                                               |                                                                                                                                                             |                                                                                                    |                                                                                                                                                      |                                                                                                 |                                                                                                                            |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified as follows:

TO HOSPITAL OR ATTENDING PHYSICIAN: The following information is required to be retained by the hospital or attending physician:  
1. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit form. The funeral director should remove carbon papers. Pages 1 and 2 should be kept with the body for 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

RECEIVED  
FBI  
JAN 10 1964

00-06311

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

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|                                                         |                                                                                                                                               |                                                                                                                                                             |                                                                          |                                                            |
|---------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Peter Scherstuck |                                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 / 9 / 86                                                                                                           |                                                                          | 2b. HOUR<br>6:50 P.M.                                      |
| 3. SEX<br>M                                             | 4. RACE<br>Cauc                                                                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 / 1 / 09                                                                                                            |                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>UKRAINE    | 7b. CITIZEN OF WHAT COUNTRY?<br>UKRAINE                                                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD. |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>unh. | 12b. KIND OF BUSINESS OR INDUSTRY<br>-                     |

|                                                                                                                   |                                                                        |                                                                            |                                     |                                                                                                 |                                                          |
|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |                                                                        | 13b. COUNTY<br>Baltimore city                                              | 13c. CITY OR TOWN<br>Baltimore city | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>5512 Bellman Ave 21225 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Danny Scherstuck                                                        |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nacie Rachevich           |                                     |                                                                                                 |                                                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><input checked="" type="checkbox"/>       | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214 306 318 | 17. INFORMANT<br>ADDRESS<br>Natalia Kurinij 5502 Bellman Ave, Baltimore MD |                                     |                                                                                                 |                                                          |

|                                                                                                                                                                                                                                                                                                                  |  |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Diffuse pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic obstructive lung disease</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|

|                                                                                                                                                                                        |                                                                        |                                                                                      |                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.<br><u>Status Post ischemic small bowel resection</u> |                                                                        |                                                                                      |                                                                                                                               |
| 19a. DATE OF OPERATION<br>5-3-86                                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Ischemic bowel     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                               |

|                                                                                                                                                                                                                                                                                                                                                          |  |                                 |                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------|----------------------------|
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-16</u> 19 <u>86</u> , to <u>5-9</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5-9</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>M. J. J. M.D. | 22c. DATE SIGNED<br>5-9-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                    |  | 22e. ADDRESS                    |                            |

|                                                                                      |                      |                                                                                 |                                                             |
|--------------------------------------------------------------------------------------|----------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                               | 23b. DATE<br>5/12/86 | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. ANDREW'S RUSSIAN<br>ORTHODOX CEMETERY | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD. |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>LILLY + ZEILER, INC. 1901 EASTERN AVE. 21231 |                      | 25a. DATE REC'D. BY REGISTRAR<br>MAY 13 1986                                    |                                                             |
|                                                                                      |                      | 25b. REGISTRAR'S SIGNATURE<br>John Davidson                                     |                                                             |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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1. The first part of the study was a pilot study. The purpose of the pilot study was to determine the feasibility of the study and to estimate the sample size required for the main study. The pilot study was conducted with 10 subjects. The results of the pilot study indicated that the study was feasible and that a sample size of 30 subjects was required for the main study.

2. The main study was conducted with 30 subjects. The purpose of the main study was to determine the effect of the intervention on the dependent variable. The results of the main study indicated that the intervention had a significant effect on the dependent variable.

3. The second part of the study was a follow-up study. The purpose of the follow-up study was to determine the long-term effects of the intervention. The follow-up study was conducted with 10 subjects. The results of the follow-up study indicated that the intervention had long-term effects on the dependent variable.

4. The third part of the study was a replication study. The purpose of the replication study was to determine the replicability of the results of the main study. The replication study was conducted with 10 subjects. The results of the replication study indicated that the results of the main study were replicable.





0 - 08096

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED AS NON-MED BY DR. SMYTH AND MR. FREEMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

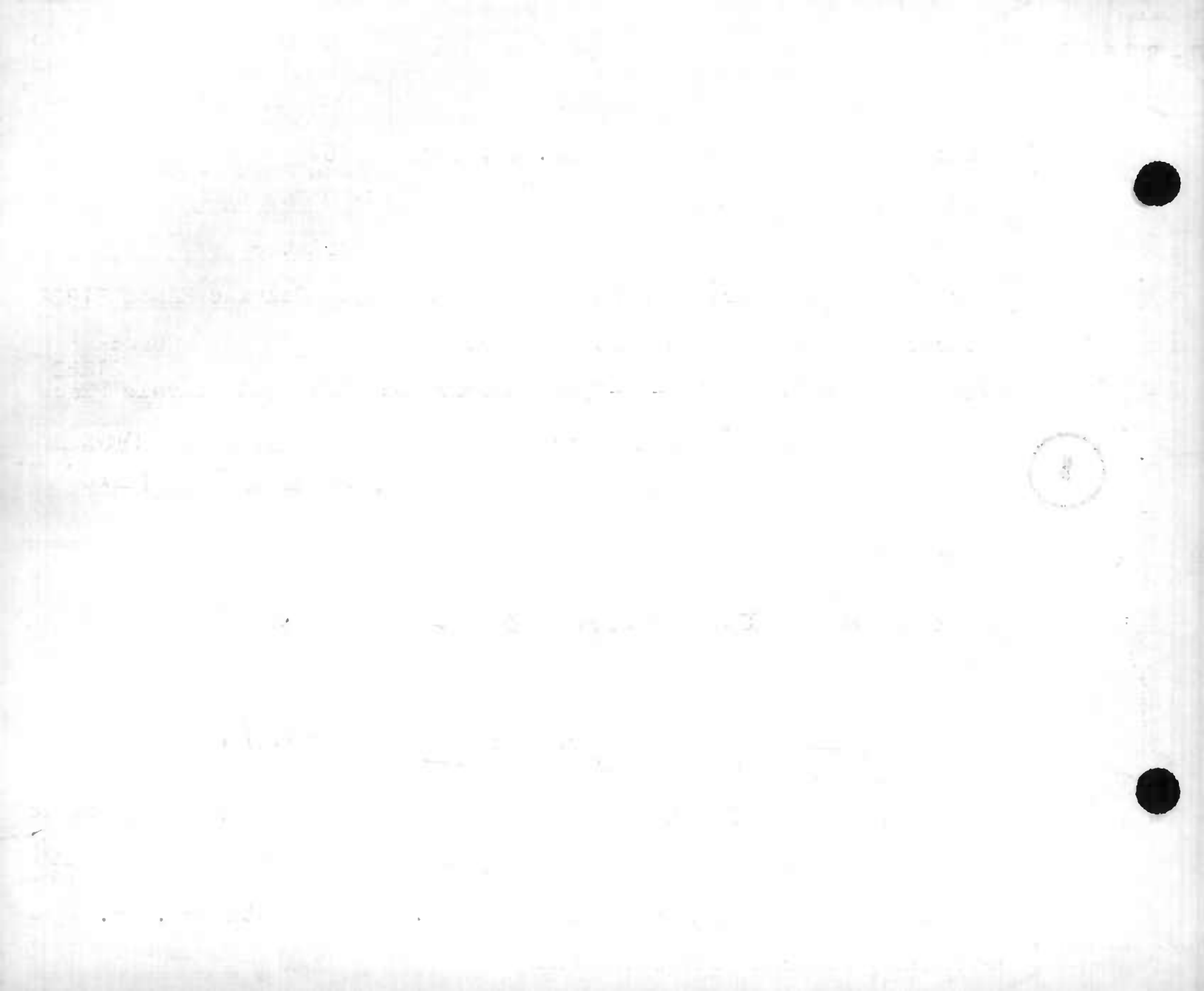
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach page 3 to this certificate. The law requires that the death certificate be executed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified and a medical certificate filed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8614115  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      |                                                                            |                                                                                                                                                             |                                                                                |                                                                                      |                                                            |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      | 20. DATE OF DEATH MONTH DAY YEAR                                           |                                                                                                                                                             |                                                                                | 21. HOUR                                                                             |                                                            |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>GEORGE SCHMIDT                                                                                                                                                                                                                                                            |  |                                                                                                                                      | MAY 23, 1986                                                               |                                                                                                                                                             |                                                                                | 11:43 M                                                                              |                                                            |                                                                                                                            |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>White                                                                                                                     |                                                                            | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 13, 1926                                                                                                            |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>60                                           |                                                            | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  |                                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |                                                            |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                                            |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Printer             |                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      | 13b. COUNTY<br>Baltimore                                                   |                                                                                                                                                             | 13c. CITY OR TOWN<br>Dundalk                                                   |                                                                                      | 13d. STREET ADDRESS / ZIP CODE<br>6900 Delvale Place 21222 |                                                                                                                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George John Schmidt                                                                                                                                                                                                                                                                      |  |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Bertha Hauck                 |                                                                                                                                                             |                                                                                |                                                                                      |                                                            |                                                                                                                            |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>yes WW1                                                                                                                                                                                                                         |  |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br>216-20-2736                                    |                                                                                                                                                             | 17. INFORMANT ADDRESS<br>Rosemary Schmidt 21222<br>6900 Delvale Place          |                                                                                      |                                                            |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (b) ISCHEMIC MYOCARDIAL REGURGITATION<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 HOUR<br>1 DAY |  |                                                                                                                                      |                                                                            |                                                                                                                                                             |                                                                                |                                                                                      |                                                            |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                             |  |                                                                                                                                      |                                                                            |                                                                                                                                                             |                                                                                |                                                                                      |                                                            |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br>5-23-86                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>ISCHEMIC HEART DISEASE |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                           |  |                                                                                                                                      | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                      |                                                            |                                                                                                                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                          |  |                                                                                                                                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |                                                                                                                                                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                                                      |                                                            |                                                                                                                            |  |
| 22a. I certify that (1) the hospital attended the deceased from 5/23/86, 19, to 5/23/86, 19, that (2) I last saw the deceased alive on 5/23, 19 86, and that in my (day/night) opinion death occurred on the date and hour and from the causes stated above, (3) I did/did not view the body after death.                       |  |                                                                                                                                      |                                                                            |                                                                                                                                                             |                                                                                |                                                                                      |                                                            |                                                                                                                            |  |
| 22b. SIGNATURE<br>Robert C. Casace                                                                                                                                                                                                                                                                                              |  |                                                                                                                                      | DEGREE<br>M.D.                                                             |                                                                                                                                                             |                                                                                | 22c. DATE SIGNED<br>5-24-86                                                          |                                                            |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CASACE                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      | 22e. ADDRESS<br>JH4 600 N. WOLFE ST. BALTO., MD 21205                      |                                                                                                                                                             |                                                                                |                                                                                      |                                                            |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                             |  |                                                                                                                                      | 23b. DATE<br>5/27/1986                                                     |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Cem.                          |                                                                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Md.  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR NAME<br>Connelly Funeral Home of Dundalk                                                                                                                                                                                                                                                                   |  |                                                                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br>JUN 2 1986                                |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br>John B. ...                                      |                                                                                      |                                                            |                                                                                                                            |  |

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00-070121-

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14115

REG. NO.

|                                                                     |  |                                                                                                                                                     |                                                                  |                                                                                                                                                             |  |                                                                                |  |                                                                                                 |                                                          |                                                                 |  |  |
|---------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MILDRED F. SCHNITZLER</b> |  |                                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>18</b> YEAR <b>86</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>12:05 PM</b>                                                    |  |                                                                                                 |                                                          |                                                                 |  |  |
| 3. SEX<br><b>Female</b>                                             |  | 4. RACE<br><b>White</b>                                                                                                                             |                                                                  | 5. DATE OF BIRTH<br>MONTH <b>SEP</b> DAY <b>30</b> YEAR <b>1915</b>                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                              |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                             |                                                          | 8. IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>             |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mississippi</b>     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                       |                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |  |                                                                                                 |                                                          |                                                                 |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hospital</b> |                                                                  |                                                                                                                                                             |  | 11a. USUAL OCCUPATION<br>(BE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b> |  |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Sales</b> |                                                                 |  |  |
| 13a. STATE<br><b>Maryland</b>                                       |  |                                                                                                                                                     |                                                                  | 13b. COUNTY<br><b>--</b>                                                                                                                                    |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                          | 13e. STREET ADDRESS / ZIP CODE<br><b>600 Light Street 21230</b> |  |  |

|                                                                                    |  |  |  |                                                                                      |  |                                            |  |                                                                |  |
|------------------------------------------------------------------------------------|--|--|--|--------------------------------------------------------------------------------------|--|--------------------------------------------|--|----------------------------------------------------------------|--|
| 14. FATHER'S NAME<br>FIRST <b>Geroge</b> MIDDLE <b>Fleming</b> LAST <b>Fleming</b> |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Pearl</b> MIDDLE <b>White</b> LAST <b>White</b> |  |                                            |  |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>     |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>220-14-8607</b>           |  | 17. INFORMANT<br><b>William W. Fleming</b> |  | ADDRESS<br><b>813 Caminito Azul Carlsbad, California 92008</b> |  |

|                                                                                                                                                               |  |                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Respiratory failure</b>                                                                                              |  |                                                 |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                |  |                                                 |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic obstructive Pulmonary Disease</b>                                                                            |  |                                                 |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

|                                                                                                                                                                                                                                                                                                                                                           |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                        |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/1</b> 19 <b>86</b> to <b>5/18</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/18</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Nerl Padgett MD MPH</b>                                                                                                                                                                                                                                                                                                              |  |                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/18/86</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Nerl Padgett</b>                                                                                                                                                                                                                                                                                              |  |                                                                        |  | 22e. ADDRESS<br><b>225 Greene St Balto Md 21201</b>                                                                                                  |  |                                                                                                                            |  |

|                                                   |  |                             |  |                                                                  |  |                                                                                                |  |
|---------------------------------------------------|--|-----------------------------|--|------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Removal</b> |  | 23b. DATE<br><b>5/18/86</b> |  | 23c. NAME OF CEMETERY OR CREMATOR<br><b>Forest Lawn Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>Glendale</b> COUNTY <b>California</b> STATE <b>California</b> |  |
|---------------------------------------------------|--|-----------------------------|--|------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|

|                                                                                    |  |                                                     |  |                                                          |  |
|------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|----------------------------------------------------------|--|
| 24. FUNERAL DIRECTOR<br><b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 20 1986</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Funder-Pendell</b> |  |
|------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|----------------------------------------------------------|--|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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5070-00



MAY 20 1968

00-06975

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual circumstances, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 1 1 7

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |                                             |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <del>Benjamin Franklin Schultz</del><br><del>Benjamin Franklin Schultz</del>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               | 2a. DATE OF DEATH MONTH DAY YEAR<br>5/16/86 |                                                                                                                                                             |  | 2b. HOUR<br>0735                                                                                                                           |  |                                                                                                                            |  |
| 2. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br>white                                                                                                                              |                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 27 07                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS                                                                                                  |  |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                        |                                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                 |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Medical Center |                                             |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br>Retired                                                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Salesman                                                                              |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br>Baltimore                                                                                                                      |                                             | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |  | 13e. STREET ADDRESS / ZIP CODE<br>707 South Conkling Street 21224                                                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Benjamin Franklin Schultz                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Grosskoff                                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-12-8557                                                                        |                                             | 17. INFORMANT ADDRESS<br>Marie Schultz 707 S. Conkling St. 21224                                                                                            |  |                                                                                                                                            |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) A systole (Cardiac Arrest.)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Prob CAD, Post op, Stroke.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Diabetes Atherosclerosis.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 min. |  |                                                                                                                                               |                                             |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>slp BKA 26° ago for gangrene                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |                                             |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br>5/15                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>gangrene of foot                                                                          |                                             |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                    |                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                            |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/13, 19 86, to 5/16, 19 86, that (I) (we) last saw the deceased alive on 5/16, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.                                                                                                                                                                                                 |  |                                                                                                                                               |                                             |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>C.D. MD                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | DEGREE                                                                                                                                        |                                             |                                                                                                                                                             |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>5/16                                                                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stone C.D.                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |                                             | 22e. ADDRESS<br>FSKMC                                                                                                                                       |  |                                                                                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br>5-17-86                                                                                                                          |                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Memorial                                                                                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westview Balto Co Md.                                                                        |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>Charles S. Zeiler & Son Inc. 901 S. Conkling St.                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                               |                                             | 25a. DATE REC'D. BY REGISTRAR<br>MAY 19 1986                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall                                                                                        |  |                                                                                                                            |  |

BP

2/1/78  
78  
Baltimore (John)

77  
Baltimore  
Baltimore (John)

77-12-22  
Baltimore (John)



2/12  
Baltimore (John)

2/12  
Baltimore (John)

00-07170

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 1 1 8

|                                                                                                                                                                                                                                                                                                                                                           |         |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                       |         | FIRST MIDDLE LAST                                                                                         |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                            |  | 2b. HOUR                                                            |                                                 |
| ESTHER                                                                                                                                                                                                                                                                                                                                                    |         | SCHWARTZ                                                                                                  |  | MAY 15, 1986                                                                                                                                                |  | 8 P. M.                                                             |                                                 |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                    | 4. RACE | 5. DATE OF BIRTH                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                                             |  | IF UNDER 1 YEAR                                                     |                                                 |
| FEMALE                                                                                                                                                                                                                                                                                                                                                    | WHITE   | MON. DAY YEAR<br>DEC. 25, 1904                                                                            |  | 81 YRS.                                                                                                                                                     |  | IF UNDER 24 HRS.                                                    |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                 |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                                 |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                  |         | USA                                                                                                       |  |                                                                                                                                                             |  | BALTIMORE CITY MD.                                                  |                                                 |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                 |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                                 |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                 |         | 3900 FORDS LA., APT. 4                                                                                    |  | NONE                                                                                                                                                        |  | NONE                                                                |                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                              |         | 13b. COUNTY                                                                                               |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?                                            |                                                 |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                  |         |                                                                                                           |  | BALTIMORE                                                                                                                                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                    |         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                             |  | 13e. STREET ADDRESS / ZIP CODE                                                                                                                              |  |                                                                     |                                                 |
| CARL SCHWARTZ                                                                                                                                                                                                                                                                                                                                             |         | ANNA KATZ                                                                                                 |  | 3900 FORDS LA., APT. 4 #21215                                                                                                                               |  |                                                                     |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                      |         | 16b. SOCIAL SECURITY NO.                                                                                  |  | 17. INFORMANT                                                                                                                                               |  |                                                                     |                                                 |
| NO                                                                                                                                                                                                                                                                                                                                                        |         | 213-90-8805M                                                                                              |  | GOLDIE SCHWARTZ APT. 4<br>3900 FORDS LA. BALTO., MD 21215                                                                                                   |  |                                                                     |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                  |         |                                                                                                           |  |                                                                                                                                                             |  |                                                                     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>                                                                                                                                                                                                                                                                                                                 |         |                                                                                                           |  |                                                                                                                                                             |  |                                                                     | <u>17 min</u>                                   |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypert. Ht Dis</u>                                                                                                                                                                                                                                                                                                  |         |                                                                                                           |  |                                                                                                                                                             |  |                                                                     | <u>14 yrs</u>                                   |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>                                                                                                                                                                                                                                                                                                    |         |                                                                                                           |  |                                                                                                                                                             |  |                                                                     | <u>20 yrs</u>                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><u>a) Diabetes Mellitus 3) Art-sclerosis 4) Hepatitis 5) Chronic Anxiety</u>                                                                                                                                           |         |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                    |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20a. AUTOPSY?                                                                                                                                               |  | 20b. IF YES, WERE YOU INTERESTED<br>IN CERTIFYING CAUSES OF DEATH?  |                                                 |
|                                                                                                                                                                                                                                                                                                                                                           |         |                                                                                                           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                    |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |  |                                                                     |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                               |         | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>77</u> , to <u>4/7</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/7</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |         |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |                                                 |
| 22b. SIGNATURE<br><u>Jonas Cohen</u>                                                                                                                                                                                                                                                                                                                      |         | DEGREE<br><u>M.D.</u>                                                                                     |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED                                                    |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JONAS COHEN, M.D.                                                                                                                                                                                                                                                                                                |         | 22e. ADDRESS<br>6702 PARK HTS. AVE. BALTO., MD                                                            |  |                                                                                                                                                             |  |                                                                     |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL                                                                                                                                                                                                                                                                                                       |         | 23b. DATE<br>MAY 16, 1986                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MIKRO KODESH-BETH ISRAEL BALTIMORE                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND    |                                                 |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215                                                                                                                                                                                                                                                              |         |                                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 21 1986                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>         |                                                 |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic or unusual condition, a medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

BP





RECEIVED  
JAN 11 1963  
U.S. CUSTOMS  
NEW YORK

00-06487

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14119

REG. NO.

|                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                  |                                                       |                                                                                                                                                             |                            |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM J. SCHWEMMER</b>                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/12/86</b> |                                                                                                                                                             | 2b. HOUR<br><b>4:12 AM</b> |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>White</b>                                                                                                                                                                                                                                                                                          |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 14 22</b>                                                                                                       |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                       |                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b>                                                                                                                                                                         |                                                       |                                                                                                                                                             |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dock Worker</b>                                     |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Motor Freight</b>                                                                                                                                                                                                                                                             |  | 13a. STREET ADDRESS / ZIP CODE<br><b>1808 DeSoto Road, 21230</b>                                                                                                                                                                                                                                                 |                                                       | 13b. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                            | 13c. STATE<br><b>Maryland</b>                                                                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Schwemmer</b>                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edna Mulligan</b>                                                                                                                                                                                                                                            |                                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                          |                            | 16b. SOCIAL SECURITY NO.<br><b>WW II 215-14-6851</b>                                                                       |  |
| 17. INFORMANT<br>ADDRESS<br><b>Jeanette E. Schwemmer, 1808 DeSoto Road 21230</b>                                                                                                                                                                                                                                      |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Possible Cardiac Arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Possible Respiratory Arrest.</b> |                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |                            |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Severe COPD: ASCVD: Acute &amp; ? chronic Renal Failure PVD; Ca of Prostate</b>                                                                                                |  |                                                                                                                                                                                                                                                                                                                  |                                                       |                                                                                                                                                             |                            |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                 |                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                                                                                                                                                                                |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                            |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                           |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                            |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/4/86</b> to <b>5/12/86</b> , that (I) (we) last saw the deceased alive on <b>5/11/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |                                                                                                                                                                                                                                                                                                                  |                                                       |                                                                                                                                                             |                            |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>HARI K BHASIN</b>                                                                                                                                                                                                                                                                                |  | DEGREE<br><b>MD</b>                                                                                                                                                                                                                                                                                              |                                                       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                            | 22c. DATE SIGNED<br><b>5/12/86</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HARI K BHASIN MD PA</b>                                                                                                                                                                                                                                                   |  | 22e. ADDRESS<br><b>606 HAMMONDS LANE BALTIMORE MD 21225</b>                                                                                                                                                                                                                                                      |                                                       |                                                                                                                                                             |                            |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>5/15/86</b>                                                                                                                                                                                                                                                                                      |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem. Baltimore</b>                                                                              |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc., 4107 Wilkens Ave.</b>                                                                                                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 14 1986</b>                                                                                                                                                                                                                                                              |                                                       | 25b. REGISTRAR'S SIGNATURE<br><b>Jana Davidson-Henderson</b>                                                                                                |                            |                                                                                                                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the funeral home prior to burial, cremation, or other disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



00-07440

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

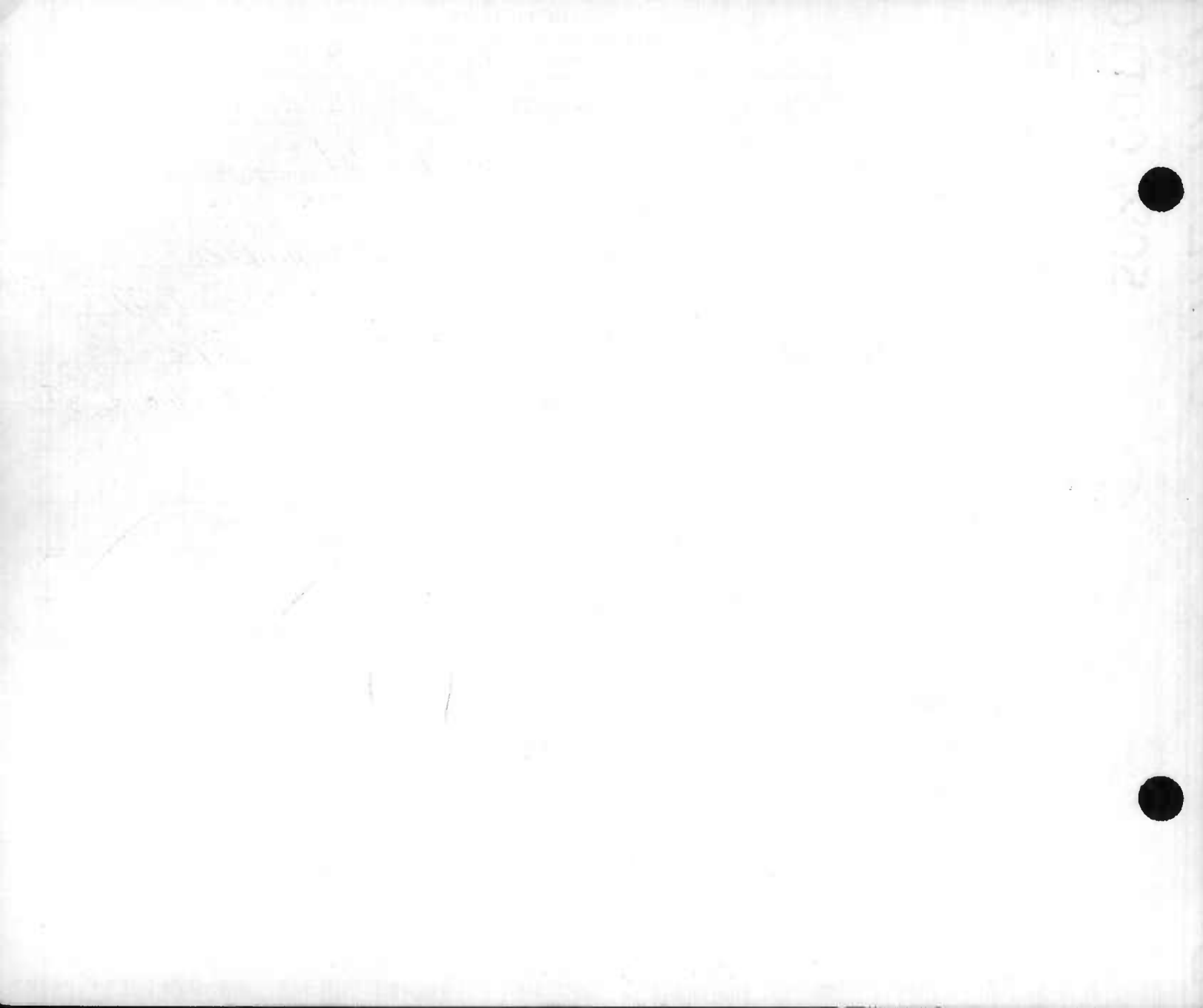
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                    |                                                                                                                                      |                                                                                                                                                             |                                                                                              | REG. NO. 86 14120                                                                 |                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                      |                                                                                                                                                             |                                                                                              |                                                                                   |                                   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>DORTHEIA SCOFIELD                                                                                                                                                                                                                                                                                              |                                                                                                                                      |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>MAY 22, 1986                                             |                                                                                   | 2b. HOUR<br>12:30 A               |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                        | 4. RACE<br>Col                                                                                                                       | 5. DATE OF BIRTH MONTH DAY YEAR<br>9-17-1924                                                                                                                |                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.                                        |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balt. Md.                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                        |                                   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |                                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                  | 13b. COUNTY                                                                                                                          | 13c. CITY OR TOWN<br>Balt.                                                                                                                                  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                   |                                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Scofield                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Ethel Thomas                                                                                                  |                                                                                              |                                                                                   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>X NO                                                                                                                                                                                                                                                                                               |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br>220-22-6262                                                                                                                     |                                                                                              | 17. INFORMANT ADDRESS<br>Mrs Vivian Scofield 9 N. Mount St 21223                  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Respiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident<br>DUE TO, OR AS A CONSEQUENCE OF (c) Probable gallbladder carcinoma<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>45 minutes<br>8 hrs<br>Years |                                                                                                                                      |                                                                                                                                                             |                                                                                              |                                                                                   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                     |                                                                                                                                      |                                                                                                                                                             |                                                                                              |                                                                                   |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                 |                                                                                                                                      |                                                                                                                                                             |                                                                                              |                                                                                   |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                      |                                                                                                                                      | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                     |                                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b; PART I OR PART 2)   |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                  |                                                                                                                                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |                                                                                              | 21f. LOCATION CITY OR TOWN COUNTY STATE                                           |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/5/86, 19 86, to March 22, 19 86, that (I) (we) last saw the deceased alive on March 21, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (you) (did not) view the body after death.                                            |                                                                                                                                      |                                                                                                                                                             |                                                                                              |                                                                                   |                                   |
| 22b. SIGNATURE<br>Ephraim Fuchs MD                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                      | DEGREE<br>MD                                                                                                                                                |                                                                                              | 22c. DATE SIGNED<br>5/22/86                                                       |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ephraim Fuchs MD                                                                                                                                                                                                                                                                                                               |                                                                                                                                      | 22e. ADDRESS<br>600 N. Wolfe St. Balt. Md. 21205                                                                                                            |                                                                                              |                                                                                   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (METHY)                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      | 23b. DATE<br>5-28-86                                                                                                                                        |                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Park                           |                                   |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balt. Co. Md.                                                                                                                                                                                                                                                                                                                |                                                                                                                                      |                                                                                                                                                             |                                                                                              |                                                                                   |                                   |
| 24. FUNERAL DIRECTOR NAME<br>Joseph L. Russ                                                                                                                                                                                                                                                                                                                             |                                                                                                                                      | ADDRESS<br>2222 W. North Ave                                                                                                                                |                                                                                              | 25a. DATE OF DEATH<br>MAY 23 1986                                                 |                                   |
| 25b. REGISTRAR'S SIGNATURE<br>John Davidson                                                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                             |                                                                                              |                                                                                   |                                   |

BP



0-06673

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach this certificate to the back of the death certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other fatal condition, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      |  |                                                                                                                                                             |                                                  |                                                                                                 |                      |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |  |                                                                                                                                                             |                                                  |                                                                                                 |                      |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>BABY BOY ELLIOTT JONES VS. SCOTT                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>MAY 10, 1986 |                                                                                                 | 2b. HOUR<br>9:42 P M |                                                                                                                            |  |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>B                                                                                                                         |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 8 86                                                                                                                   |                                                  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>2                                           |                      | IF UNDER 1 YEAR<br>IF UNDER 24 HRS                                                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |                      |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |                                                                                                                                                             |                                                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                                                                          |  | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                              |                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                      | 13e. STREET ADDRESS / ZIP CODE<br>1603 E. 28th STREET 21218                                                                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>ELLIOTT SCOTT SR.                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SYLVIA JONES                                                                                                  |                                                  |                                                                                                 |                      |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>N/A                                                                                                      |  | 17. INFORMANT ADDRESS<br>FLORENCE JONES 1603 E. 28th ST. 21218                                                                                              |                                                  |                                                                                                 |                      |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>persistent fetal circulation</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>20 min</u><br><u>2.5 days</u> |  |                                                                                                                                      |  |                                                                                                                                                             |                                                  |                                                                                                 |                      |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>R pneumonia</u>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |  |                                                                                                                                                             |                                                  |                                                                                                 |                      |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  |                                                                                                                                                             |                                                  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                  |                                                                                                 |                      |                                                                                                                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                  |                                                                                                 |                      |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> 19 <u>86</u> , to <u>5/10</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/10</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                         |  |                                                                                                                                      |  |                                                                                                                                                             |                                                  |                                                                                                 |                      |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Mark Lawrence Hudak</u>                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                      |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                  |                                                                                                 |                      | 22c. DATE SIGNED<br><u>5-11-86</u>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>MARK L. HUDAK</u>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                      |  | 22e. ADDRESS<br><u>18 LAUREA COURT TOWSON MD 21204</u>                                                                                                      |                                                  |                                                                                                 |                      |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>5-16-86                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL                                                                                                            |                                                  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>ANNE ARUNDEL MARYLAND                                |                      |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>WM.C.MARCH F/H INC. 1101 E. NORTH AVE.                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 15 1986                                                                                                                |                                                  | 25b. REGISTRAR'S SIGNATURE<br><u>J. B. Davidson</u>                                             |                      |                                                                                                                            |  |





00-06259

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14122  
REG. NO.

FOR  
STATE  
REGISTRAR

|                                                                                          |  |                                                                                   |  |                                                                                                                                                             |  |
|------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Harvey E. Scott SR.</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-7-86</b>                              |  | 2b. HOUR<br><b>2<sup>00</sup> a.m.</b>                                                                                                                      |  |
| 3. SEX<br><b>Male</b>                                                                    |  | 4. RACE<br><b>Black</b>                                                           |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5-23-36</b>                                                                                                        |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b>                                             |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                       |  | 8. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>                       |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b>                          |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Horse groomer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                 |  | 13. STREET ADDRESS / ZIP CODE<br><b>733 McCabe Avenue 21212</b>                                                                                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Scott</b>                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Taylor</b>          |  | 16. SOCIAL SECURITY NO.<br><b>218-32-1646</b>                                                                                                               |  |
| 17. INFORMANT<br>ADDRESS<br><b>Catherine Scott 733 McCabe Avenue</b>                     |  | 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  | 18b. SOCIAL SECURITY NO.<br><b>218-32-1646</b>                                                                                                              |  |

|                                                                                                                                                       |  |                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Head and Neck Cancer</b>                                                                                     |  |                                                 |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                 |  |                                                 |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                        |  |                                                                                                                                                 |  |                                                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                                                                                                                                                                                                                               |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                   |  | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-2</b> , 19 <b>86</b> , to <b>5-7</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5-7</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>Daniel C. Hagan MD.</b>                           |  | DEGREE<br><b>MD.</b>                                                                                                                            |  | 22c. DATE SIGNED<br><b>5-7-86</b>                                                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Daniel C. Hagan MD.</b>                                                                                                                                                                                                                                                                                             |  | 22e. ADDRESS                                                           |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                                                               |  |

|                                                                        |  |                             |  |                                                                 |  |                                                                     |  |
|------------------------------------------------------------------------|--|-----------------------------|--|-----------------------------------------------------------------|--|---------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                       |  | 23b. DATE<br><b>5/13/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>March Funeral Homes 1101 East North Ave</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 12 1986</b>             |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>                  |  |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

BP

25% COTTON LABEL

MADE IN U.S.A.



MAY 15 1964

00-06688

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 1 2 3  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                    |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                        |  |
|------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RALPH</b>                                   |  | FIRST <b>SCOTT</b>                                                                                                                          |  | LAST                                                                                                                                                        |  | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>12</b> YEAR <b>86</b>                                |  | 2b. HOUR <b>9 P</b> M                                                  |  |
| 3. SEX<br><b>MALE</b>                                                              |  | 4. RACE<br><b>BLACK</b>                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>11</b> YEAR <b>14</b>                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA.</b>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY</b> MD.                              |  |                                                                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1010 EAST BIDDLE STREET</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>N/A</b>                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |
| 13a. STATE<br><b>MARYLAND</b>                                                      |  | 13b. COUNTY<br><b></b>                                                                                                                      |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1010 EAST BIDDLE STREET 21202</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>HENRY</b> MIDDLE <b></b> LAST <b>SCOTT</b>           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ELNORA</b> MIDDLE <b></b> LAST <b>HUBBARD</b>                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b> |  | 16b. SOCIAL SECURITY NO.<br><b>213126352</b>                                                                                                |  | 17. INFORMANT<br>ADDRESS<br><b>LAURA SCOTT 1010 E. BIDDLE STREET</b>                                                                                        |  |                                                                                                 |  |                                                                        |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

|                                                                                                         |                                      |                                                                   |  |
|---------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------------------------|--|
| IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b>                                                      |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 MIN.</b> |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                          |                                      |                                                                   |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last. | (b) <b>ADENOCARCINOMA of STOMACH</b> | <b>7/84</b>                                                       |  |
|                                                                                                         | DUE TO, OR AS A CONSEQUENCE OF       |                                                                   |  |
|                                                                                                         | (c) <b></b>                          |                                                                   |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/12</b> 19 <b>86</b> , to <b>5/12</b> 19 <b>86</b> , that (I) (we) last<br>saw the deceased alive on <b>5/12</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Dorothy Snow</b>                                                                                                                                                                                                                                                                                                                              |  | DEGREE<br><b>M.D.</b>                                                  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/13/86</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DOROTHY SNOW</b>                                                                                                                                                                                                                                                                                                       |  | 22e. ADDRESS                                                           |  |                                                                                                                                            |  |                                                                                                                               |  |

|                                                                                                |  |                             |  |                                                                |  |                                                                                  |  |
|------------------------------------------------------------------------------------------------|--|-----------------------------|--|----------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                               |  | 23b. DATE<br><b>5-16-86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MARYLAND NATIONAL</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>LAUREL</b> COUNTY <b>MARYLAND</b> STATE <b></b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>WM.C.MARCH F/H INC. 1101 EAST NORTH AVENUE</b> ADDRESS <b></b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1986</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><b></b>                                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

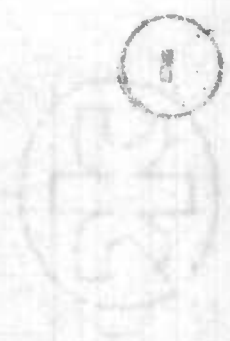
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

QUALITY SERVICE  
LAWSON LUMBER CO. 11125A SOUTH BEND, IN  
RYAN L. KOTZAK 1982

00000-00

FOR COTTON MOTORS & PUMPS



575" [unclear] X [unclear]

00-07986

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 1 2 4  
REG. NO.

|                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                                     |                                                                                                 |                                                                                                                               |                                                          |                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-----------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Richard Scott, Sr                                                                                                                                                                                                                                             |  |                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 25 86                         |                                                                                                                                                             |                                                                                | 2b. HOUR<br>6:40 P.M.                                                                                                                               |                                                                                                 |                                                                                                                               |                                                          |                                         |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>Black                                                                                                            |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 29 20                                                                                                               |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65<br>YRS.                                                                                                       |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |                                                          |                                         |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>S.C.                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                         |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. city MD.                                                                                             |                                                                                                 |                                                                                                                               |                                                          |                                         |  |
| 10. CITY OR TOWN OF DEATH<br>Balto                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |                                                                        |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Self employed                                                                   |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |                                                          |                                         |  |
| 13a. STATE<br>Md                                                                                                                                                                                                                                                                                                          |  |                                                                                                                             | 13b. COUNTY                                                            |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                                                 |                                                                                                                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                               | 13e. STREET ADDRESS / ZIP CODE<br>6 N. Rosedale St 21229 |                                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Issac Scott                                                                                                                                                                                                                                                                     |  |                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lottie Spearman       |                                                                                                                                                             |                                                                                | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                              |                                                                                                 |                                                                                                                               |                                                          | 16b. SOCIAL SECURITY NO.<br>248-24-5454 |  |
| 17. INFORMANT<br>ADDRESS<br>Imogene Scott 6. N. Rosedale St                                                                                                                                                                                                                                                               |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                                     |                                                                                                 |                                                                                                                               |                                                          |                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Resp. arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Metastatic cancer                                                          |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                                     |                                                                                                 |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH          |                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                       |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                                     |                                                                                                 |                                                                                                                               |                                                          |                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                    |  |                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                |                                                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                          |                                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                  |  |                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                                                     |                                                                                                 |                                                                                                                               |                                                          |                                         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                              |  |                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET                                                        |                                                                                                                                                     | CITY OR TOWN                                                                                    |                                                                                                                               | COUNTY STATE                                             |                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/18/86, 19 86, to 5/25 19 86, that (I) (we) lost<br>saw the deceased alive on 5/25 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                                     |                                                                                                 |                                                                                                                               |                                                          |                                         |  |
| 22b. SIGNATURE<br>Erin Weiner                                                                                                                                                                                                                                                                                             |  |                                                                                                                             | DEGREE                                                                 |                                                                                                                                                             |                                                                                | ATTENDING<br>PHYSICIAN <input type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br>5/25/86                                                                                                   |                                                          |                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Eric Weiner                                                                                                                                                                                                                                                                  |  |                                                                                                                             | 22e. ADDRESS<br>Sinai Hosp. of Balto                                   |                                                                                                                                                             |                                                                                |                                                                                                                                                     |                                                                                                 |                                                                                                                               |                                                          |                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Burial                                                                                                                                                                                                                                                                       |  |                                                                                                                             | 23b. DATE<br>5/31/86                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                      |                                                                                                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Co MD                                |                                                                                                                               |                                                          |                                         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>March Funeral Home West 4300 Abasco Avenue                                                                                                                                                                                                                                                |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br>MAY 29 1986                                                                                                        |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>John Davidson                                                                                   |                                                          |                                         |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

18050-00



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*[Faint, illegible handwritten text]*

00-07390

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 4 1 2 5

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         |                                                                                           |                                                                                                                                                             |                                                                   |                                                                                         |                                                                                                 |                                                                                                                            |                                                                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM HENRY SCOTT JR.</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 15 86</b>                                     |                                                                                                                                                             | 2b. HOUR<br>10 <sup>26</sup> P.M.                                 |                                                                                         |                                                                                                 |                                                                                                                            |                                                                  |  |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 4 RACE<br><b>B</b>                                                                                                                      |                                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 6 27</b>                                                                                                         |                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.                                       |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>So. Carolina</b>                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                              |                                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                       |                                                                                                 |                                                                                                                            |                                                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY HOSPITAL</b> |                                                                                           |                                                                                                                                                             |                                                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AUTO REPAIRS</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                                  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                  |  |                                                                                                                                         | 13b. COUNTY<br><b>Cecil</b>                                                               |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>North East</b>                            |                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br><b>405 Maryland Ave. 21901</b> |  |
| FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM SCOTT</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANGRONE SANDERS</b>                   |                                                                                                                                                             |                                                                   |                                                                                         |                                                                                                 |                                                                                                                            |                                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>11/50-12/52 217-22-1501</b> |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Carolyn E. Scott same as above</b> |                                                                                         |                                                                                                 |                                                                                                                            |                                                                  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>NON-SMALL CELL CA OF LUNG</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                         |                                                                                           |                                                                                                                                                             |                                                                   |                                                                                         |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>—</b>         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>CONSTRICTIVE PERICARDITIS</b>                                                                                                                                                                                                               |  |                                                                                                                                         |                                                                                           |                                                                                                                                                             |                                                                   |                                                                                         |                                                                                                 |                                                                                                                            |                                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                          |                                                                                                                                                             |                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                             |  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                         |                                                                                                                                                             |                                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)         |                                                                                                 |                                                                                                                            |                                                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                          |  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                    |                                                                                                                                                             |                                                                   | 21f. LOCATION<br>STREET                                                                 |                                                                                                 | CITY OR TOWN COUNTY STATE                                                                                                  |                                                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/27</b> 19 <b>86</b> to <b>5/15</b> 19 <b>86</b> that (I) (we) lost saw the deceased alive on <b>5/15</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |                                                                                                                                         |                                                                                           |                                                                                                                                                             |                                                                   |                                                                                         |                                                                                                 |                                                                                                                            |                                                                  |  |
| 22b. SIGNATURE<br><b>C. Helinski M.D.</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |                                                                                           |                                                                                                                                                             |                                                                   | DEGREE                                                                                  |                                                                                                 | 22c. DATE SIGNED<br><b>5/15/86</b>                                                                                         |                                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. Helinski M.D.</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                         |                                                                                           |                                                                                                                                                             |                                                                   | 22e. ADDRESS<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b>                                  |                                                                                                 |                                                                                                                            |                                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         | 23b. DATE<br><b>5/19/86</b>                                                               |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Carmel Cemetery</b>  |                                                                                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>North East Cecil Md.</b>                       |                                                                                                                            |                                                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Arnold Beard 353 Fountain St. HavreDeGrace, Md.</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         |                                                                                           |                                                                                                                                                             |                                                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 22 1986</b>                                     |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                           |                                                                  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the supporting Pages 1 and 2 and forward within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

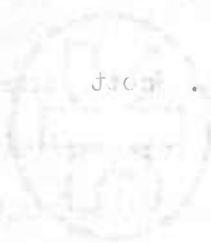


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00-05832

DIVISION OF VITAL RECORDS, 2D1 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, medical examiner must be notified for further advice.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

14126

|                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |                                                                                               |                                                                                                                                                             |                                          |                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                            |                                                                  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>William Norman Sears Jr.</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 5, 1986</b>                                     |                                                                                                                                                             | 2b. HOUR<br><b>8:21</b> M                |                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                            |                                                                  |  |
| 1. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>Caucasian</b>                                                                                                                   |                                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 8, 1917</b>                                                                                                 |                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                                                                                                                                                                                                                                                                       |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS.<br>HOURS MIN.                                                        |                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |                                                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                                                                                                                                                                                                       |                                                                                                 |                                                                                                                            |                                                                  |  |
| 11. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |                                                                                               |                                                                                                                                                             |                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>                                                                                                                                                                                                                                      |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Amstar</b>                                                                         |                                                                  |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                        |  |                                                                                                                                               | 13b. COUNTY<br><b>Baltimore</b>                                                               |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Randallstown</b> |                                                                                                                                                                                                                                                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br><b>3705 Nauset Place 21133</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Norman Sears Sr.</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary P. Boettinger</b>                    |                                                                                                                                                             |                                          | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW 2</b>                                                                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                  |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-09-5785</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               | 17. INFORMANT<br><b>Randallstown</b> ADDRESS MD<br><b>Mrs. Margaret Sears 3705 Nauset Pl.</b> |                                                                                                                                                             |                                          | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Inferior myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Severe Coronary artery disease</b> |                                                                                                 |                                                                                                                            |                                                                  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Anteroseptal myocardial infarction, 1971</b>                                                                                                                                                                               |  |                                                                                                                                               |                                                                                               |                                                                                                                                                             |                                          |                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                            |                                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |                                                                                               |                                                                                                                                                             |                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                    |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                    |                                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                          |                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                            |                                                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |                                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                          |                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                            |                                                                  |  |
| 22a. I certify that (X) this hospital attended the deceased from <b>April 30</b> 19 <b>86</b> , to <b>May 5</b> 19 <b>86</b> , that (X) (we) last saw the deceased alive on <b>May 5</b> 19 <b>86</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (and) (us) (we) saw the body after death. |  |                                                                                                                                               |                                                                                               |                                                                                                                                                             |                                          |                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                            |                                                                  |  |
| 22b. SIGNATURE<br><i>Timothy Low</i>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                               |                                                                                               | DEGREE<br><b>M.D.</b>                                                                                                                                       |                                          |                                                                                                                                                                                                                                                                                                                         |                                                                                                 | 22c. DATE SIGNED<br><b>5/5/86</b>                                                                                          |                                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Timothy Low, M.D.</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |                                                                                               | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                                        |                                          |                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                            |                                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>5-8-86</b>                                                                                                                    |                                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Pk</b>                                                                                          |                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville Carroll MD</b>                                                                                                                                                                                                                                              |                                                                                                 |                                                                                                                            |                                                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                               |                                                                                               | 24b. ADDRESS<br><b>8728 Liberty Rd. Randallstown, MD 21133</b>                                                                                              |                                          | 25a. DATE REC'D BY REGISTRAR<br><b>MAY 6 1986</b>                                                                                                                                                                                                                                                                       |                                                                                                 |                                                                                                                            |                                                                  |  |

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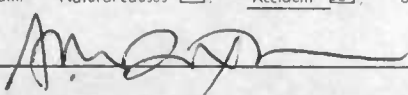

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00-06679

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6  
 REG. NO. 14127

1- FOR STATE REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                              |                   |                                                                                                                                                          |  |                                                                               |  |                                                                                       |  |                                      |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|--------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                              |                   | 2a. DATE KNOWN OF DEATH                                                                                                                                  |  |                                                                               |  | 2b. HOUR                                                                              |  |                                      |  |
| MICHAEL Allen SEIDEL                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                              |                   | MONTH DAY YEAR<br>5 13 19 86                                                                                                                             |  |                                                                               |  | 11:57 PM                                                                              |  |                                      |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR.                                                                                                                                        |  | 7. IF UNDER 24 HRS.                                                           |  | 2c. DATE PRONOUNCED DEAD                                                              |  |                                      |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                                   | White   | October 3 1955               | 30 YRS.           | MONTHS DAYS                                                                                                                                              |  | HOURS MIN.                                                                    |  | MONTH DAY YEAR<br>5 13 19 86                                                          |  |                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                              |         | 7b. CITIZEN OF WHAT COUNTRY? |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                  |  |                                      |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                               |         | U.S.A.                       |                   |                                                                                                                                                          |  |                                                                               |  | Baltimore City MD.                                                                    |  |                                      |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                              |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                                                                                                 |  |                                                                               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                         |  |                                      |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                              |                   | University Hosp. (STU)                                                                                                                                   |  |                                                                               |  | Accounting Dept. Balto. Co.                                                           |  |                                      |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                             |         |                              |                   | 13b. COUNTY                                                                                                                                              |  | 13c. CITY OR TOWN                                                             |  | 13d. INSIDE CITY LIMITS?                                                              |  | 13e. STREET ADDRESS                  |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                    |         |                              |                   |                                                                                                                                                          |  | Baltimore                                                                     |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  | 2703 East Strathmore Road 21214 Ave. |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                              |                   |                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME                                                      |  |                                                                                       |  |                                      |  |
| Walter Timothy Seidel                                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                              |                   |                                                                                                                                                          |  | Joan Lee Rodbell                                                              |  |                                                                                       |  |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                     |         |                              |                   | 16b. SOCIAL SECURITY NO.                                                                                                                                 |  | 17. INFORMANT ADDRESS                                                         |  |                                                                                       |  |                                      |  |
| no                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                              |                   | 217-48-1993                                                                                                                                              |  | Walter T. Seidel 9412 Fullerdale Ave.                                         |  |                                                                                       |  |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                              |         |                              |                   |                                                                                                                                                          |  |                                                                               |  |                                                                                       |  |                                      |  |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                                            |         |                              |                   |                                                                                                                                                          |  |                                                                               |  |                                                                                       |  |                                      |  |
| IMMEDIATE CAUSE (a) <u>Thoracic trauma</u>                                                                                                                                                                                                                                                                                                                                                                                                             |         |                              |                   |                                                                                                                                                          |  |                                                                               |  |                                                                                       |  |                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                              |                   |                                                                                                                                                          |  |                                                                               |  |                                                                                       |  |                                      |  |
| (b) _____                                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                              |                   |                                                                                                                                                          |  |                                                                               |  |                                                                                       |  |                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                              |                   |                                                                                                                                                          |  |                                                                               |  |                                                                                       |  |                                      |  |
| (c) _____                                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                              |                   |                                                                                                                                                          |  |                                                                               |  |                                                                                       |  |                                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                                                                    |         |                              |                   |                                                                                                                                                          |  |                                                                               |  |                                                                                       |  |                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                              |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                        |  |                                                                               |  | 20. AUTOPSY?                                                                          |  |                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                              |                   |                                                                                                                                                          |  |                                                                               |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  |                                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                         |         |                              |                   | 21b. TIME OF INJURY                                                                                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                                                                       |  |                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                              |                   | 11:10M. 5-13-1986                                                                                                                                        |  | Operator of motorcycle/parked auto collision.                                 |  |                                                                                       |  |                                      |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                      |         |                              |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                              |  | 21f. LOCATION                                                                 |  | CITY OR TOWN                                                                          |  | COUNTY STATE                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                              |                   | road                                                                                                                                                     |  | 3700 blk. Glenmore Ave.,                                                      |  | Balto. City                                                                           |  | MD                                   |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |                              |                   |                                                                                                                                                          |  |                                                                               |  |                                                                                       |  |                                      |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                              |                   | TITLE (SPECIFY)                                                                                                                                          |  |                                                                               |  | DATE SIGNED                                                                           |  |                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                     |         |                              |                   | M.D. Assistant                                                                                                                                           |  |                                                                               |  | MEDICAL EXAMINER 5-14-86                                                              |  |                                      |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                              |                   | ADDRESS                                                                                                                                                  |  |                                                                               |  |                                                                                       |  |                                      |  |
| Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                              |                   | 111 Penn St., Balto., MD                                                                                                                                 |  |                                                                               |  | 21201                                                                                 |  |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                              |         |                              |                   | 23b. DATE                                                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY                                            |  | 23d. LOCATION                                                                         |  | CITY STATE                           |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                              |                   | 5-17-1986                                                                                                                                                |  | Parkwood                                                                      |  | Baltimore                                                                             |  | Md.                                  |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                              |                   |                                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR                                                 |  | 25b. REGISTRAR'S SIGNATURE                                                            |  |                                      |  |
| Leonard J. Ruck, Inc. 5305 Harford Road                                                                                                                                                                                                                                                                                                                                                                                                                |         |                              |                   |                                                                                                                                                          |  | MAY 15 1986                                                                   |  |  |  |                                      |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201  
  
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSFER, OR CREMATION RECORD. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

14128

|                                                                                                                                                          |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARY M. SEIDLER</b>                                                                                            |  | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>10</b> YEAR <b>86</b>                                                                                  |  | 2b. HOUR<br><b>8:55 P.M.</b>                                                                                                                                                                                                                                                                                                                                    |  |
| 3. SEX<br><b>Female</b>                                                                                                                                  |  | 4. RACE<br><b>White</b>                                                                                                                           |  | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>7</b> YEAR <b>07</b>                                                                                                                                                                                                                                                                                                  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                                                                                                                                                                                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANCIS SCOTT KEY MED. CENTER</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                                                                                                                                                                                                                                               |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LEATHER MARKER</b>                                                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SHOE FACTORY</b>                                                                                          |  | 13a. STREET ADDRESS / ZIP CODE<br><b>2000 O'Dell Ave. Apt. 1008</b>                                                                                                                                                                                                                                                                                             |  |
| 13a. STATE<br><b>MD.</b>                                                                                                                                 |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                                   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                           |  |
| 14. FATHER'S NAME<br>FIRST <b>JESSIE</b> MIDDLE <b>BARE</b> LAST <b>WOODIE</b>                                                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MAHALA</b> MIDDLE <b>WOODIE</b> LAST <b>WOODIE</b>                                                           |  | 16. SOCIAL SECURITY NO.<br><b>238-07-5764</b>                                                                                                                                                                                                                                                                                                                   |  |
| 17. INFORMANT<br><b>EDWIN BARE (BROTHER)</b>                                                                                                             |  | 18. ADDRESS<br><b>1224 FRAILEY WAY 21205</b>                                                                                                      |  | 19. DATE OF OPERATION<br><b>5/10/86</b>                                                                                                                                                                                                                                                                                                                         |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  | 21. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5/10/86</b>                                                                                 |  | 21c. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                |  | 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                 |  | 22. I certify that (I) (this hospital) attended the deceased from <b>5 AM 5/10</b> 19 <b>86</b> , to <b>9 PM 5/10</b> 19 <b>86</b> , that (we) last saw the deceased alive on <b>5/10</b> 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |
| 22b. SIGNATURE<br><b>D. Royall</b>                                                                                                                       |  | 22c. DATE SIGNED<br><b>5/10/86</b>                                                                                                                |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Royall</b>                                                                                                                                                                                                                                                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                               |  | 23b. DATE<br><b>5/14/86</b>                                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>                                                                                                                                                                                                                                                                                                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                                                                       |  | 24. FUNERAL HOME<br>NAME <b>Schimmek Funeral Home, Inc.</b> ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>                                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 13 1986</b>                                                                                                                                                                                                                                                                                                             |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                         |  | 25c. DATE OF DEATH<br><b>5/10/86</b>                                                                                                              |  | 25d. TIME OF DEATH<br><b>8:55 P.M.</b>                                                                                                                                                                                                                                                                                                                          |  |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Cardiac arrest**  
DUE TO, OR AS A CONSEQUENCE OF  
(b) **Trifascicular block**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  
(c) **Acute myocardial infarction**  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
**30 minutes**  
**30 minutes**  
**18 hours**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

**No Hypertension, Type II AODM.**





00-07716

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

14129

|                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |                                                |                                                                                                                                                             |                    |                                                                                      |  |                                                                                                 |  |                                                                                                                            |  |                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOHN SEIGLE                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 23 86 |                                                                                                                                                             | 2b. HOUR<br>7 55 M |                                                                                      |  |                                                                                                 |  |                                                                                                                            |  |                                                        |  |
| 3 SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>CAUCASIAN                                                                                                               |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 12 08                                                                                                              |                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                       |  | IF UNDER 24 HRS<br>HOURS MIN.                                                                                              |  |                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                |                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALT. CITY MD.                               |  |                                                                                                 |  |                                                                                                                            |  |                                                        |  |
| 10. CITY OR TOWN OF DEATH<br>BALT                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALT GEN'L Hosp |                                                |                                                                                                                                                             |                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Machine Operator |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Md. Glass Co.                                              |  |                                                                                                                            |  |                                                        |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |                                                | 13b. COUNTY                                                                                                                                                 |                    | 13c. CITY OR TOWN<br>BALTIMORE                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                                            |  | 13e. STREET ADDRESS / ZIP CODE<br>2123 MAISEL ST 21230 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HENRY J. SEIGLE                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CARRIE M. SMITH                                                                                            |                    |                                                                                      |  |                                                                                                 |  |                                                                                                                            |  |                                                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |                                                | 16b. SOCIAL SECURITY NO.<br>WW II<br>214014757                                                                                                              |                    | 17. INFORMANT<br>ADDRESS<br>Elizabeth Seigle, 2123 Maisel St., 21230                 |  |                                                                                                 |  |                                                                                                                            |  |                                                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic bronchogenic carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Acute pulmonary edema<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST |  |                                                                                                                                    |                                                |                                                                                                                                                             |                    |                                                                                      |  |                                                                                                 |  |                                                                                                                            |  |                                                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>ASCVD                                                                                                                                                                                                                                |  |                                                                                                                                    |                                                |                                                                                                                                                             |                    |                                                                                      |  |                                                                                                 |  |                                                                                                                            |  |                                                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                    |                                                                                      |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                   |  |                                                                                                                                    |                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |  |                                                                                                 |  |                                                                                                                            |  |                                                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                 |  |                                                                                                                            |  |                                                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                                         |  |                                                                                                                                    |                                                |                                                                                                                                                             |                    |                                                                                      |  |                                                                                                 |  |                                                                                                                            |  |                                                        |  |
| 22b. SIGNATURE<br>J. Giralt                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |                                                | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                    |                                                                                      |  | 22c. DATE SIGNED                                                                                |  |                                                                                                                            |  |                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. GIRALT                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |                                                | 22e. ADDRESS<br>3001 S. HANOVER BALT MD 21230                                                                                                               |                    |                                                                                      |  |                                                                                                 |  |                                                                                                                            |  |                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |                                                | 23b. DATE<br>5/27/86                                                                                                                                        |                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk.                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Maryland                          |  |                                                                                                                            |  |                                                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.,                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |                                                | ADDRESS<br>4107 Wilkens Ave.                                                                                                                                |                    | 25a. DATE REC'D. BY REGISTRAR<br>MAY 27 1986                                         |  | 25b. REGISTRAR'S SIGNATURE                                                                      |  |                                                                                                                            |  |                                                        |  |

MEDICAL CERTIFICATION

19

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

RECEIVED  
MAY 11 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



00-07711

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14130

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                      |                                                                              |                                                                                                                                                             |                                                                                                      |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPH SELBY</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                      | 7a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 25 86</b>                        |                                                                                                                                                             |                                                                                                      | 7b. HOUR<br><b>2:45 A M</b>                                                                                                                |                                                                                                 |                                                                                                                            |                                                                     |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>W</b>                                                                  |                                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 15 04</b>                                                                                                        |                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS                                                                                           |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                           |                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>                                                                           |                                                                                                 |                                                                                                                            |                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>South Baltimore M.</b> |                                                                              |                                                                                                                                                             |                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Paint Brush Maker</b>                                               |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dell's Co.</b>                                                                     |                                                                     |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                      | 13b. COUNTY<br><b>Baltimore</b>                                              |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br><b>3603 MCTAVISH AVE MD 21229</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter Selby</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Dengus</b>     |                                                                                                                                                             |                                                                                                      |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                |  |                                                                                      | 16b. SOCIAL SECURITY NO.<br><b>214 014 032</b>                               |                                                                                                                                                             | 17. INFORMANT<br><b>Deborah Godwin</b>                                                               |                                                                                                                                            |                                                                                                 |                                                                                                                            | ADDRESS<br><b>3603 McTavish Ave., 21229</b>                         |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Aortic Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ruptured Aortic Aneurysm</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                      |                                                                              |                                                                                                                                                             |                                                                                                      |                                                                                                                                            |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>                                                                                                                                                                                                                                         |  |                                                                                      |                                                                              |                                                                                                                                                             |                                                                                                      |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                     |  |
| 19a. DATE OF OPERATION<br><b>5/14/86</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ruptured Aneurysm</b> |                                                                                                                                                             |                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                         |  |                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>            |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                       |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                     |  |                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3001 South Hanover St Baltimore Maryland</b> |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/14/86</b> , 19____, to <b>5/25/86</b> , 19____, that (I) (we) last saw the deceased alive on <b>5/25/86</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                           |  |                                                                                      |                                                                              |                                                                                                                                                             |                                                                                                      |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                     |  |
| 22b. SIGNATURE<br><b>Jorge E. Colden</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                      | DEGREE<br><b>COLDEN</b>                                                      |                                                                                                                                                             |                                                                                                      | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>5/25/86</b>                                                                                         |                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JORGE E. COLDEN</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                      | 22e. ADDRESS<br><b>3001 South Hanover St Baltimore MD 21230</b>              |                                                                                                                                                             |                                                                                                      |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                      | 23b. DATE<br><b>5/28/86</b>                                                  |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                                    |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |                                                                                                                            |                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.,</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                      | ADDRESS<br><b>4107 Wilkens Ave.</b>                                          |                                                                                                                                                             |                                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 27 1986</b>                                                                                        |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>J. H. [Signature]</b>                                                                     |                                                                     |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

00-07711

SECHI-MITO-300



00-06683

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE DEATH CERTIFICATE. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6                                                                                                                                                                                                                                                                                                                                              |  |                         |  |                                                                                                                                        |  |                                                                               |  |                                                                                                                                                             |  |                                                                                                             |  | REG. NO. 4131                                       |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Marion H. Selby</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                         |  |                                                                                                                                        |  |                                                                               |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>5/ 12/ 19 86</b> |  | 2b. HOUR <b>5:00</b>                                |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 31 1919</b>                                                                                   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>66</b> YRS.                           |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                    |  | 7c. DATE PRONOUNCED DEAD<br><b>5/ 12/ 19 86</b>                                                             |  | 7d. HOUR <b>P</b>                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                        |  |                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                                          |  |                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2126 Penrose Ave.</b> |  |                                                                               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Receptionist</b>                                                                        |  |                                                                                                             |  | 12b. KIND OF BUSINESS<br><b>Accident Fund State</b> |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                         |  | 13b. COUNTY                                                                                                                            |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br><b>2126 Penrose Avenue<br/>Baltimore, Maryland 21223</b>                             |  |                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Henry Selby</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                         |  |                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Estelle West</b>          |  |                                                                                                                                                             |  |                                                                                                             |  |                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No.</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>213-14-0973</b>                                                                                         |  | 17. INFORMANT<br><b>Miss Roberta Selby</b>                                    |  |                                                                                                                                                             |  | 17b. ADDRESS<br><b>2126 Penrose Avenue<br/>Baltimore, Maryland 21223</b>                                    |  |                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                          |  |                         |  |                                                                                                                                        |  |                                                                               |  |                                                                                                                                                             |  |                                                                                                             |  |                                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                    |  |                         |  |                                                                                                                                        |  |                                                                               |  |                                                                                                                                                             |  |                                                                                                             |  |                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                      |  |                                                                               |  |                                                                                                                                                             |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  |                                                     |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                 |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                                                                                                                                             |  |                                                                                                             |  |                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                              |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |                                                                                                                                                             |  |                                                                                                             |  |                                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> <u>Inspection</u> <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |                                                                                                                                        |  |                                                                               |  |                                                                                                                                                             |  |                                                                                                             |  |                                                     |  |
| ACTUAL SIGNATURE _____                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         |  |                                                                                                                                        |  | TITLE (SPECIFY)<br><b>Assistant</b>                                           |  | M.D. _____                                                                                                                                                  |  | DATE SIGNED <b>5/13/86</b>                                                                                  |  |                                                     |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                         |  |                                                                                                                                        |  | ADDRESS <b>111 Penn St.</b>                                                   |  |                                                                                                                                                             |  |                                                                                                             |  |                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                         |  | 23b. DATE<br><b>5/17/1986</b>                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>            |  |                                                                                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                                    |  |                                                     |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>NUFFNER &amp; SONS FUNERAL HOME, INC.</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                         |  |                                                                                                                                        |  | 24b. ADDRESS<br><b>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>           |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1986</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><i>Davidson-Rendall</i>                                                       |  |                                                     |  |

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

60301-1



00-09347

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 1 3 2  
REG. NO.

|                                                                                                                                                                                       |                                                                                                                                        |                                                                                                                                                             |                                                                                     |                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES ALBERT SEITLER</b>                                                                                                                       |                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH <b>MAY</b> DAY <b>31</b> YEAR <b>86</b>                                                                                          |                                                                                     | 2b. HOUR<br><b>7:20 A.M.</b>                                     |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                 | 4. RACE<br><b>CAUCASIAN</b>                                                                                                            | 5. DATE OF BIRTH<br>MONTH <b>UNKNOWN</b> DAY <b>24</b> YEAR <b>24</b>                                                                                       |                                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>disabled</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>CITY</b> 13c. CITY OR TOWN <b>BALTIMORE</b> |                                                                                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             | 13e. STREET ADDRESS / ZIP CODE<br><b>UNKNOWN 99999</b>                              |                                                                  |

|                                                                                        |                                                                                          |                                                                                                      |  |
|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--|
| 14. FATHER'S NAME<br>FIRST <b>PHILLIP J.</b> MIDDLE <b>SEITLER</b> LAST <b>SEITLER</b> |                                                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>GRACE</b> MIDDLE <b>LITZ</b> LAST <b>LITZ</b>                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>NOT APPLICABLE UNKNOWN</b> | 17. INFORMANT<br>ADDRESS <b>WESTMINSTER, MD.</b><br><b>JOSEPH SEITLER 1051 CHERRY TOWN RD. #1157</b> |  |

|                                                                                                                                                                                                                                                                                  |  |                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                        |  |                                                                                                                                                      |                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                       |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/24</b> 19 <b>86</b> , to <b>5/31</b> 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/31</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                      |                                                                                                                               |
| 22b. SIGNATURE<br><b>ADAB</b> MD.                                                                                                                                                                                                                                                                                                                                  |  |                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>5/31/86</b>                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DASILVA ANTHONY A.</b>                                                                                                                                                                                                                                                                                                 |  | 22e. ADDRESS<br><b>PROVIDENT HOSPITAL, BALTIMORE</b>                   |  |                                                                                                                                                      |                                                                                                                               |

|                                                     |                                  |                                                                |                                                                            |
|-----------------------------------------------------|----------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>CREMATION</b> | 23b. DATE<br><b>JUNE 3, 1986</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CARROLL CREMATION</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>HAMPSTEAD CARROLL MD.</b> |
|-----------------------------------------------------|----------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------|

|                                                                                       |                                                       |                                                            |
|---------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------|
| 24. FUNERAL DIRECTOR<br>NAME <b>Robert A. Meyer</b> ADDRESS <b>91 Willis St 21157</b> | 25a. DATE DECEASED BY REGISTRAR<br><b>JUN 06 1986</b> | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Rodgers</b> |
|---------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



10-08301



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward it to the State Dept. of Health and Mental Hygiene prior to burial or cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an additional autopsic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 1 3 3  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        | FIRST MIDDLE LAST                                                                                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                             |  | 2b. HOUR MIN.                                                                                                           |                                                              |
| REV. WALTER                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | H. SEWELL                                                                                                                                                |  | 5/18/86                                                                                      |  | 2:40 AM                                                                                                                 |                                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                       | 4. RACE                                                                                                | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                              |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                             |                                                              |
| MALE                                                                                                                                                                                                                                                                                                                                                                                         | BLACK                                                                                                  | 4 23 1905                                                                                                                                                |  | 81 YRS                                                                                       |  |                                                                                                                         |                                                              |
| 7a. BIRTHPLACE (COUNTRY)                                                                                                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                         |  |                                                                                                                         |                                                              |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                     | U. S. A.                                                                                               |                                                                                                                                                          |  | BALTIMORE CITY MD.                                                                           |  |                                                                                                                         |                                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                                              |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                    | KESWICK NURSING HOME                                                                                   |                                                                                                                                                          |  | MINISTER                                                                                     |  | UNITED METHODIST CH.                                                                                                    |                                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                   | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE                                                                                          |                                                              |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | BALTIMORE                                                                                                                                                |  |                                                                                              |  | 3715 LOCHEARN DR. BALTIMORE, MARYLAND 21207                                                                             |                                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                               |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |  |                                                                                                                         |                                                              |
| JOHN SEWELL                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | MARY WATTS                                                                                                                                               |  | NO                                                                                           |  |                                                                                                                         |                                                              |
| 16b. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | 17. INFORMANT ADDRESS                                                                                                                                    |  | 17b. SOCIAL SECURITY NO.                                                                     |  |                                                                                                                         |                                                              |
| 215-10-0098A                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        | MARGARET E. SEWELL BALTIMORE, MARYLAND 21207                                                                                                             |  | 215-10-0098A                                                                                 |  |                                                                                                                         |                                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Artery Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>34 years</u> |                                                                                                        |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>16 hr</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |                                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                           |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |  |                                                                                                                         |                                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                       |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                         |                                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                  |                                                                                                        |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |                                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |  | DEGREE                                                                                       |  | 22c. DATE SIGNED                                                                                                        |                                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |  | 22e. ADDRESS                                                                                 |  | 5-18-86                                                                                                                 |                                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        | 23b. DATE                                                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY                                                           |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                 |                                                              |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | 5/21/1986                                                                                                                                                |  | ST. REST CEMETERY                                                                            |  | HARMONS, MARYLAND                                                                                                       |                                                              |
| 24. FUNERAL HOME NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |  | 25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE                                   |  |                                                                                                                         |                                                              |
| Nutter & Sons Funeral Home, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |  | MAY 22 1986                                                                                  |  |                                                                                                                         |                                                              |

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00-08547

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

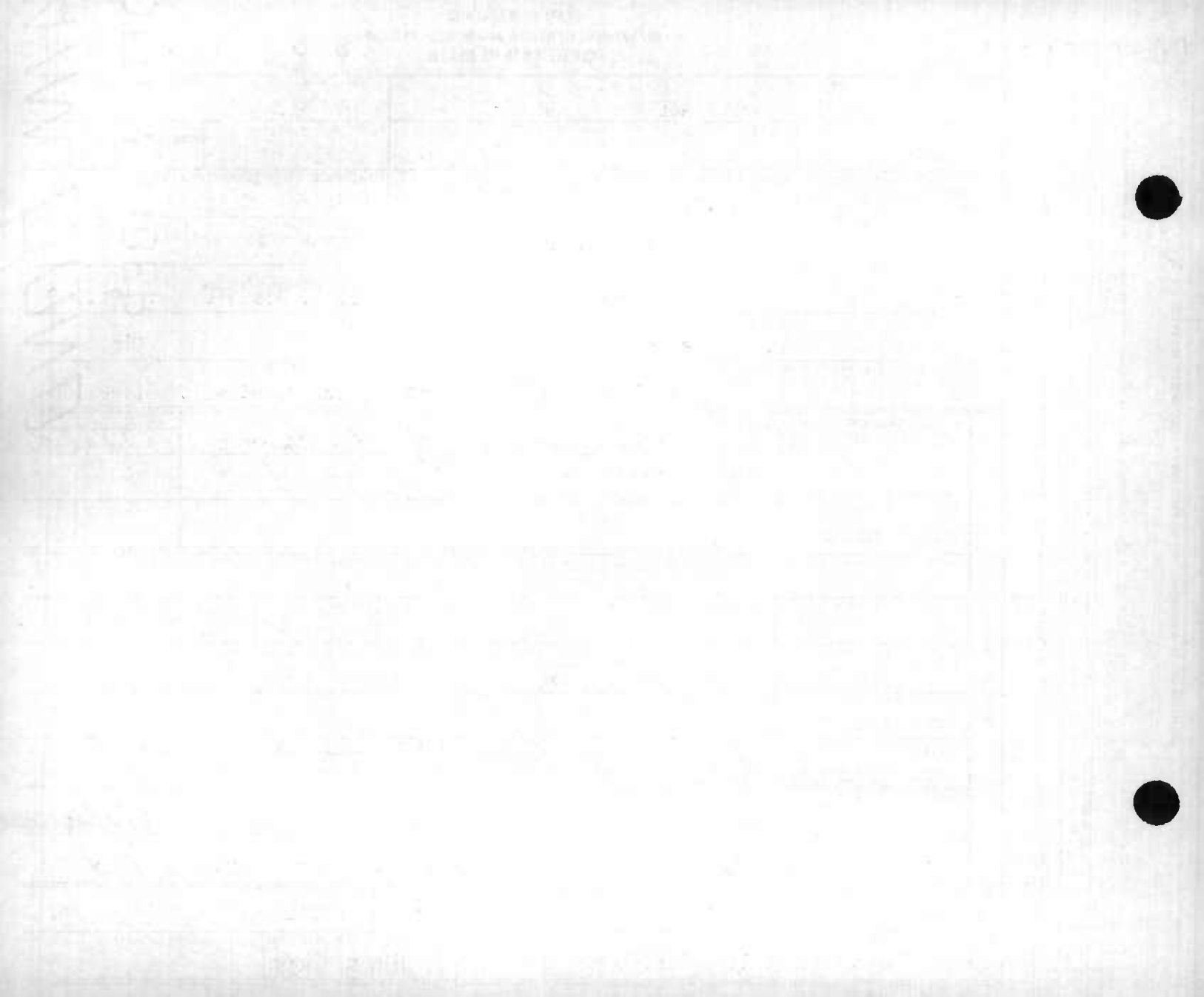
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                         |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                      |                                   | 8 6 1 4 1 3 4<br>REG. NO.                                                                                                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                      |                                   |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SUDIE ELIZABETH SHAMLEY                                                                                                                                                                                                                                                                                               |  |                                                                                                                                     |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 31, 1986                                                                                        |  |                                                                                      | 2b. HOUR<br>M                     |                                                                                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>Black                                                                                                                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 17 35                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.                                                                                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                            |                                   | IF UNDER 24 HRS.                                                                                                           |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>North Carolina                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                                                                |  |                                                                                      |                                   |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>633 N. AISQUITH STREET |  |                                                                                                                                                             |  |                                                                                                                                            |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UNEMPLOYED       |                                   | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                      |                                   |                                                                                                                            |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY                                                                                                                         |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |  | 13e. STREET ADDRESS / ZIP CODE<br>633 N. Aisquith St. Apt. 10G 21202                 |                                   |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William H. Peaton                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Clemons                                                                                              |  |                                                                                                                                            |  |                                                                                      |                                   |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-30-4917                                                              |  | 17. INFORMANT ADDRESS<br>Charles Shamley 633 N. Aisquith St. Apt 10G                                                                                        |  |                                                                                                                                            |  |                                                                                      |                                   |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>adenocarcinoma of the lung</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                      |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>12 months</u>                                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                       |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                      |                                   |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                     |  |                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>8 (P.M.) 5 31 1986                                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                      |                                   |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                               |  |                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                      |                                   |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7</u> 19 <u>85</u> , to <u>5</u> 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>5/14</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                      |                                   |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Robert T Smith</u><br>DEGREE <u>MD</u>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                     |  |                                                                                                                                                             |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                      | 22c. DATE SIGNED<br><u>6/2/86</u> |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Robert T Smith</u>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                     |  |                                                                                                                                                             |  | 22e. ADDRESS<br><u>1000 Eager St Balto, Md</u>                                                                                             |  |                                                                                      |                                   |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>6/6/86                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                                                               |  |                                                                                      |                                   |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>March Funeral Homes 1101 East North Avenue                                                                                                                                                                                                                                                                           |  |                                                                                                                                     |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 5 1986                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>William Randall</u>                                 |                                   |                                                                                                                            |  |

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00-07737

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                  |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                 |                                                     | 8614135<br>REG. NO.                                                                                                                   |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Dorothy M. Shandrowski                                                                                                                                                                                                                                                                       |  |                                                                                                                                |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 26 86                                    |  |                                                                                                 | 2b. HOUR<br>908 M                                   |                                                                                                                                       |  |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                       |  | 4 RACE<br>White                                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 14 23                                                                                                                  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.                                      |  | IF UNDER 1 YEAR MONTHS DAYS                                                                     |                                                     | IF UNDER 23 HRS. HOURS MIN.                                                                                                           |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |                                                                                                 |                                                     |                                                                                                                                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St Agnes Hospital |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Assembly Line |  |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Western Elect. |                                                                                                                                       |  |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                |  | 13b. COUNTY<br>A.A.                                                                                                                                         |  | 13c. CITY OR TOWN<br>Baltimore                                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                     | 13e. STREET ADDRESS / 710 CODE<br>247 West Meadow Road 21225                                                                          |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Rodger Evans                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Geraldine Giles                                                                                               |  |                                                                                |  |                                                                                                 |                                                     |                                                                                                                                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                |  |                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>175-20-4845                                                                                                                     |  | 17. INFORMANT ADDRESS<br>Joseph J. Shandrowski Same as 13e                     |  |                                                                                                 |                                                     |                                                                                                                                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SEVERE BICAPITAL BRONCHOPNEUMONIA<br>DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC SMALL CELL CARCINOMA OF LUNG<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>DAYS MONTHS |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                 |                                                     |                                                                                                                                       |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a                                                                                                                                                                                                                     |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                 |                                                     |                                                                                                                                       |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                              |  |                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                                                                                                 |                                                     |                                                                                                                                       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                          |  |                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                 |                                                     |                                                                                                                                       |  |  |
| 22a. I certify that I (this hospital) attended the deceased from 5/20, 19 86, to 5/25, 19 86, that I (we) lost saw the deceased alive on 5/25, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.                                          |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                 |                                                     |                                                                                                                                       |  |  |
| 22b. SIGNATURE<br>Steven H. Pearlman                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                |  |                                                                                                                                                             |  | DEGREE<br>M.D.                                                                 |  |                                                                                                 | 22c. DATE SIGNED<br>5/26/86                         |                                                                                                                                       |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STEVEN H. PEARLMAN                                                                                                                                                                                                                                                                                           |  |                                                                                                                                |  |                                                                                                                                                             |  | 22e. ADDRESS<br>ST. AGNES HOSPITAL 500 S. CAROL AVE                            |  |                                                                                                 |                                                     |                                                                                                                                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                |  | 23b. DATE<br>5/29/86                                                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                      |  |                                                                                                 | 23d. LOCATION<br>Baltimore COUNTY A.A. STATE Md     |                                                                                                                                       |  |  |
| 24. FUNERAL DIRECTOR<br>George J. Gonce 4001 Ritchie Hwy Balto Md                                                                                                                                                                                                                                                                                     |  |                                                                                                                                |  |                                                                                                                                                             |  | 25a. DATE RECEIVED BY REGISTRAR<br>MAY 27 1986                                 |  |                                                                                                 |                                                     |                                                                                                                                       |  |  |
|                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                |  |                                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson                                    |  |                                                                                                 |                                                     |                                                                                                                                       |  |  |

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 1 3 6

REG. NO.

|                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                             |                                                       |                                                                                                                                                            |  |                                                                                                |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>SALLIE HARRISON SHELTON</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                             | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>04-15-86</b> |                                                                                                                                                            |  | 2b HOUR<br><b>1125A<sub>M</sub></b>                                                            |  |                                                                                                                            |  |
| 3 SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                        |  | 4 RACE<br><b>B</b>                                                                                                                          |                                                       | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 15 01</b>                                                                                                        |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>85</b>                                                                     |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA.</b>                                                                                                                                                                                                                                                                                   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                |                                                       | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |                                                                                                                            |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |                                                       |                                                                                                                                                            |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>POST OFFICE</b>          |  | 12b KIND OF BUSINESS OR INDUSTRY                                                                                           |  |
| 13a STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                             |  | 13b COUNTY                                                                                                                                  |                                                       | 13c CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13. STREET ADDRESS / ZIP CODE<br><b>1901 BARCLAY ST. 21218</b>                                                             |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CUPID HOPPER</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                             |                                                       | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SALLIE JACKSON</b>                                                                                      |  |                                                                                                |  |                                                                                                                            |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                         |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>230-07-8969</b>                                                                |                                                       | 17 INFORMANT ADDRESS<br><b>ARDELL HARRISON 1901 BARCLAY STREET</b>                                                                                         |  |                                                                                                |  |                                                                                                                            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b>                                                                                                                                                                                    |  |                                                                                                                                             |                                                       |                                                                                                                                                            |  |                                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min.</b>                                                             |  |
| Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                                                                                                |  |                                                                                                                                             |                                                       |                                                                                                                                                            |  |                                                                                                |  |                                                                                                                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a<br><b>Diabetes Mellitus</b>                                                                                                                                                                             |  |                                                                                                                                             |                                                       |                                                                                                                                                            |  |                                                                                                |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |                                                       |                                                                                                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                           |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |  |                                                                                                |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                                |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-10-1986</b> to <b>4-15-1986</b> , that (I) (we) lost<br>saw the deceased alive on <b>4-15-1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                             |                                                       |                                                                                                                                                            |  |                                                                                                |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>James H. Bonts MD.</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             |                                                       | DEGREE<br><b>MD.</b>                                                                                                                                       |  |                                                                                                |  | 22c. DATE SIGNED<br><b>4-15-86</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES H. BONT'S MD.</b>                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |                                                       | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                             |  |                                                                                                |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>4-19-86</b>                                                                                                                 |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE</b>                                                                                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                        |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WM.C. MARCH F/H INC. 1101 E. NORTH AVE.</b>                                                                                                                                                                                                                                                   |  |                                                                                                                                             |                                                       |                                                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 18 1986</b>                                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Richard Anderson</b>                                                                      |  |

MEDICAL CERTIFICATION

83

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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30% COTTON 1954

WOLF BRAND



MADE IN U.S.A.

00-06904

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 1 3 7  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |                                                                  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |                                                |  |                                                  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------|--|--------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROBERT G. SHEPHERD</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>15</b> YEAR <b>86</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>M</b>                                                                 |  |                                                                                                                            |  |                                                |  |                                                  |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>Caucasian</b>                                                                                                        |                                                                  | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>26</b> YEAR <b>15</b>                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                                                             |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |  |                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WISCONSIN</b>                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                      |                                                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore CITY, MD.</b>                   |  |                                                                                                                            |  |                                                |  |                                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |                                                                  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CHEMIST</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RESEARCH</b>                                                                       |  |                                                |  |                                                  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>21218</b> 13c. CITY OR TOWN <b>BALTIMORE</b>                                                                                                                                                                                                |  |                                                                                                                                    |                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3900 N. CHARLES ST. 21218</b>                   |  |                                                                                                                            |  |                                                |  |                                                  |  |
| 14. FATHER'S NAME<br>FIRST <b>FREDERICK</b> MIDDLE <b>W.</b> LAST <b>SHEPHERD</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>PAULINE</b> MIDDLE <b></b> LAST <b>WELLGE</b>                                                                          |  |                                                                                      |  |                                                                                                                            |  |                                                |  |                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br><b>218-10-8147</b>                                                                                     |                                                                  | 17. INFORMANT<br>ADDRESS <b>21218</b><br><b>HELEN D. SHEPHERD 3900 N. CHARLES ST.</b>                                                                       |  |                                                                                      |  |                                                                                                                            |  |                                                |  |                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Cancer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |                                                                                                                                    |                                                                  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                               |  |                                                                                                                                    |                                                                  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |                                                |  |                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |                                                                  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                |  |                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                  |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)                                                                               |  |                                                                                      |  |                                                                                                                            |  |                                                |  |                                                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                      |  |                                                                                                                            |  |                                                |  |                                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-12</b> , 19 <b>86</b> , to <b>5-15</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5-15</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.               |  |                                                                                                                                    |                                                                  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |                                                |  |                                                  |  |
| 22b. SIGNATURE<br><b>Daniel C. Hagan</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |                                                                  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |                                                                                      |  | 22c. DATE SIGNED<br><b>5-15-86</b>                                                                                         |  |                                                |  |                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Daniel C. Hagan DO.</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |                                                                  | 22e. ADDRESS                                                                                                                                                |  |                                                                                      |  |                                                                                                                            |  |                                                |  |                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><b>MAY 17, '86</b>                                                                                                    |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OLD ST. PAUL CEMETERY</b>                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN <b>KENT COUNTY, MARYLAND</b> COUNTY STATE              |  |                                                                                                                            |  |                                                |  |                                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM E. JOHNSON</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |                                                                  | ADDRESS<br><b>8521 LOCH RAVEN BLVD.</b>                                                                                                                     |  |                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 19 1986</b>                                                                        |  |                                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-06511

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 1 3 8  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                     |                                                                       |                                                                                                                                                            |                                                               |                                                                                                |                                                                 |                                                                                                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Dorothy M. Sheppard</i>                                                                                                                                                                                                                                                        |  |                                                                                                                                     | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><i>05 10 86</i>                 |                                                                                                                                                            |                                                               | 2b HOUR<br><i>1015 AM</i>                                                                      |                                                                 |                                                                                                                              |  |
| 3 SEX<br><i>F</i>                                                                                                                                                                                                                                                                                                                            |  | 4 RACE<br><i>B</i>                                                                                                                  |                                                                       | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>1 9 32</i>                                                                                                         |                                                               | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>54</i> YRS                                                |                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><i>0 0 0 0</i>                                                                  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>S.C.</i>                                                                                                                                                                                                                                                                                      |  | 7b CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                           |                                                                       | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City MD</i>                                |                                                                 |                                                                                                                              |  |
| 10 CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                 |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Univ of Maryland</i> |                                                                       |                                                                                                                                                            |                                                               | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>            |                                                                 | 12b KIND OF BUSINESS OR INDUSTRY                                                                                             |  |
| 13a STATE<br><i>Md</i>                                                                                                                                                                                                                                                                                                                       |  | 13b COUNTY                                                                                                                          |                                                                       | 13c CITY OR TOWN<br><i>Baltimore</i>                                                                                                                       |                                                               | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                 | 13e STREET ADDRESS / ZIP CODE<br><i>3501 W. Franklin St 21229</i>                                                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Felix King</i>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                     |                                                                       | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Ratta King</i>                                                                                          |                                                               |                                                                                                |                                                                 |                                                                                                                              |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>                                                                                                                                                                                                                                                            |  | 16b SOCIAL SECURITY NO.<br><i>248-50-6818</i>                                                                                       |                                                                       | 17 INFORMANT ADDRESS<br><i>Joseph Sheppard 3501 W. Franklin St.</i>                                                                                        |                                                               |                                                                                                |                                                                 |                                                                                                                              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>overwhelming sepsis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>metastatic malignant histiocytoma</i>                            |  |                                                                                                                                     |                                                                       |                                                                                                                                                            |                                                               |                                                                                                |                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                           |  |                                                                                                                                     |                                                                       |                                                                                                                                                            |                                                               |                                                                                                |                                                                 |                                                                                                                              |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                            |                                                               | 20a AUTOPSY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                                                                 | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                      |  |                                                                                                                                     | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>5/10 2 19 86</i> |                                                                                                                                                            |                                                               | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                                                                 |                                                                                                                              |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                  |  |                                                                                                                                     | 21e PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |                                                                                                                                                            |                                                               | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                 |                                                                                                                              |  |
| 22a I certify that (I) (this hospital) attended the deceased from <i>5/10 2 19 86</i> to <i>5/10 19 86</i> , that (I) (we) lost<br>saw the deceased alive on <i>5/10 19 86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                     |                                                                       |                                                                                                                                                            |                                                               |                                                                                                |                                                                 |                                                                                                                              |  |
| 22b SIGNATURE<br><i>R. Hesley MD</i>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                     |                                                                       |                                                                                                                                                            |                                                               | DEGREE                                                                                         |                                                                 | 22c DATE SIGNED<br><i>5/10/86</i>                                                                                            |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>R. Hesley</i>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |                                                                       |                                                                                                                                                            |                                                               | 22e ADDRESS<br><i>Univ of Md</i>                                                               |                                                                 |                                                                                                                              |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>Burial</i>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     | 23b DATE<br><i>5/15/86</i>                                            |                                                                                                                                                            | 23c NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn Cemetery</i> |                                                                                                | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto Co MD</i> |                                                                                                                              |  |
| 24 FUNERAL DIRECTOR<br><i>March Funeral Home West 4300 Wabash Avenue</i>                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |                                                                       |                                                                                                                                                            |                                                               | 25a DATE REC'D. BY REGISTRAR<br><i>MAY 14 1986</i>                                             |                                                                 | 25b REGISTRAR'S SIGNATURE<br><i>John Davidson</i>                                                                            |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please inform the funeral director that the certificate has been filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WILLIAM

COLLIER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. **VERY IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other medical condition, the medical examiner will have to be notified.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified prior to

## MEDICAL CERTIFICATION

| STATE OF MARYLAND                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|--------------------------------------|--|-------------------------------------------------|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| STUART S. SHEUBROOK SR. CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                              |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| REG. NO. 86 14139                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                       |  | FIRST                                                                                                     |  | MIDDLE                                                                                                                                                       |  | LAST                                                                                            |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR  |  | 2b. HOUR                                        |  |
| Stuart                                                                                                                                                                                                                                                                                                                    |  | S.                                                                                                        |  | Sheubrook                                                                                                                                                    |  | Sr.                                                                                             |  | May 22, 1986                         |  | 5:05p M                                         |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                    |  | 4. RACE                                                                                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR                                                                                                                           |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)                                                              |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS    |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| Male                                                                                                                                                                                                                                                                                                                      |  | White                                                                                                     |  | June 4, 1916                                                                                                                                                 |  | 69 YRS                                                                                          |  |                                      |  |                                                 |  |
| 9a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                              |  | 9b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                            |  |                                      |  |                                                 |  |
| Maryland                                                                                                                                                                                                                                                                                                                  |  | U.S.A.                                                                                                    |  |                                                                                                                                                              |  | BALTIMORE CITY MD.                                                                              |  |                                      |  |                                                 |  |
| 11. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                 |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |                                      |  |                                                 |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                 |  | SAINT AGNES HOSPITAL                                                                                      |  | Engineer                                                                                                                                                     |  | Westinghouse                                                                                    |  |                                      |  |                                                 |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY                                                                                               |  | 13c. CITY OR TOWN                                                                                                                                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE       |  |                                                 |  |
| Maryland                                                                                                                                                                                                                                                                                                                  |  | Baltimore                                                                                                 |  | Catonsville                                                                                                                                                  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  | 284 Bloomsbury Avenue 21228          |  |                                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                             |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| Howard                                                                                                                                                                                                                                                                                                                    |  | Sheubrook                                                                                                 |  | Ada                                                                                                                                                          |  | Schaeffer                                                                                       |  | 16a. SOCIAL SECURITY NO. 215-01-8022 |  |                                                 |  |
| 16b. ADDRESS                                                                                                                                                                                                                                                                                                              |  | 17. INFORMANT                                                                                             |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| 800 Stamford Road                                                                                                                                                                                                                                                                                                         |  | Stuart S. Sheubrook Jr. Baltimore, MD. 21229                                                              |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                 |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                              |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| IMMEDIATE CAUSE (a) Cardiac arrest                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                             |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| (b) Generalized Pseudomonas sepsis &                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| (c) Multiple organ failure                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| (c) Perforated Peptic Ulcer with Fungal peritonitis                                                                                                                                                                                                                                                                       |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                      |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| COPD, Malnutrition.                                                                                                                                                                                                                                                                                                       |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20a. AUTOPSY?                                                                                                                                                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                  |  |                                      |  |                                                 |  |
| 4/26/86                                                                                                                                                                                                                                                                                                                   |  | Perforated Peptic ulcer & Peritonitis                                                                     |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                          |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                        |  |                                      |  |                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                               |  |                                                                                                 |  |                                      |  |                                                 |  |
|                                                                                                                                                                                                                                                                                                                           |  | P.M. 19                                                                                                   |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                            |  |                                                                                                 |  |                                      |  |                                                 |  |
|                                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 26th, 1986, to May 22, 1986, that (I) (we) last saw the deceased alive on May 22, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                           |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                            |  | DEGREE                                                                                                    |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                              |  | 22c. DATE SIGNED                                                                                |  |                                      |  |                                                 |  |
| Viney Setya, M.D.                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  |                                                                                                                                                              |  | 5/22/86                                                                                         |  |                                      |  |                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS                                                                                              |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
|                                                                                                                                                                                                                                                                                                                           |  | 900 S. Caton Ave., Baltimore, Maryland 21229                                                              |  |                                                                                                                                                              |  |                                                                                                 |  |                                      |  |                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                              |  | 23b. DATE                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |  |                                      |  |                                                 |  |
| Burial                                                                                                                                                                                                                                                                                                                    |  | 5/26/86                                                                                                   |  | Druid Ridge                                                                                                                                                  |  | Pikesville Maryland                                                                             |  |                                      |  |                                                 |  |
| 24. FUNERAL HOME OR ADDRESS                                                                                                                                                                                                                                                                                               |  | 24a. DATE REC'D. BY REGISTRAR                                                                             |  | 24b. REGISTRAR'S SIGNATURE                                                                                                                                   |  |                                                                                                 |  |                                      |  |                                                 |  |
| Leroy M. & Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, MD. 21228                                                                                                                                                                                                                          |  | MAY 23 1986                                                                                               |  | Julia Davidson-Randall                                                                                                                                       |  |                                                                                                 |  |                                      |  |                                                 |  |



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

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|                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                    |                                                                                                                                                                   |                                                                                    |                                                                                                                            |                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>William Shipley</b>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                    |                                                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 11 86</b>                              |                                                                                                                            | 2b. HOUR<br>M<br><b></b>                                |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE<br><b>Black</b>                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 11 11</b>                                                                                                              |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.               |                                                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                  |                                                                                                                            |                                                         |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |                                                                                                                                                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>            |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                    | 13b. COUNTY<br><b></b>                                                                                                                                            | 13c. CITY OR TOWN<br><b>Balto.</b>                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William A. Shipley</b>                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gertrude Gould</b>                                                                                            |                                                                                    |                                                                                                                            |                                                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br><b>212-18-8979</b>                                                                                     |                                                                                                                                                                   | 17. INFORMANT<br>ADDRESS<br><b>Joan Taylor 1645 N. Bentalou St.</b>                |                                                                                                                            |                                                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>END STAGE CORD, POSS. MI</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>INTERSTITIAL PNEUMONITIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                    |                                                                                                                                                                   |                                                                                    |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b></b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ASCVD, CHF</b>                                                                                                                                                                                                                                                           |                                                                                                                                    |                                                                                                                                                                   |                                                                                    |                                                                                                                            |                                                         |
| 19a. DATE OF OPERATION<br><b>9 9</b>                                                                                                                                                                                                                                                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>                                                                        |                                                                                                                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>12 13 85</b>                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b></b>                                                                         |                                                                                    |                                                                                                                            |                                                         |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b>                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2435 W. BELVEDERE 21215</b>                                                                               |                                                                                    |                                                                                                                            |                                                         |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/11 19 86</b> to <b>5/11 19 86</b> , that (I) (we) last saw the deceased alive on <b>5/11 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                                                                          |                                                                                                                                    |                                                                                                                                                                   |                                                                                    |                                                                                                                            |                                                         |
| 22b. SIGNATURE<br><b>A. C. ENRIQUE</b>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                    | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                    | 22c. DATE SIGNED<br><b>MAY 16 1986</b>                                                                                     |                                                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. C. ENRIQUE</b>                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                    | 22e. ADDRESS<br><b>2435 W. BELVEDERE 21215</b>                                                                                                                    |                                                                                    |                                                                                                                            |                                                         |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                | 23b. DATE<br><b>5/17/86</b>                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>                                                                                                      |                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                                                        |                                                         |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F.H. West</b>                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                    | ADDRESS<br><b>4300 Wabash Ave.</b>                                                                                                                                |                                                                                    | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 16 1986</b>                                                                        |                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                    | 25b. REGISTRAR'S SIGNATURE<br><b>June Anderson-Jones</b>                                                                                                          |                                                                                    |                                                                                                                            |                                                         |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Then please remove certificate from pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14141  
REG. NO.1. FOR  
STATE  
REGISTRAR

|                                                                                                                 |                                                                                                                                     |                                                                                                                                                             |                                                                              |                                                                                                 |                                                      |
|-----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Keroy B Shore                                                            |                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 3 / 86                                                                                                             |                                                                              | 2b. HOUR<br>2:58 PM                                                                             |                                                      |
| 3 SEX<br>Male                                                                                                   | 4 RACE<br>White                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 18 20                                                                                                               |                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                                      |                                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt City MD                                            |                                                      |
| 10. CITY OR TOWN OF DEATH<br>Balt                                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Univ of Maryland Hosp. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORK YEAR)<br>Stock Clerk |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Paint Manufact. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>MD |                                                                                                                                     | 13b. CITY OR TOWN<br>Balt                                                                                                                                   |                                                                              | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Blair                                                                 |                                                                                                                                     | 15. MOTHER'S NAME<br>FIRST MIDDLE LAST<br>Laura                                                                                                             |                                                                              | 16. ADDRESS<br>NA                                                                               |                                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                     |                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br>WW II 191-12-1710                                                                                                               |                                                                              | 17. INFORMANT<br>Geraldine M. Lee, 92 Mary Lane E-103 Glen Burnie, MD                           |                                                      |

|                                                                                                                                                                                                                                                                                   |  |                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Pulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Lung Cancer.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: \_\_\_\_\_

## MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                                 |                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                  |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                               |                                                                                                                               |
| 22. I certify that (1) this hospital attended the deceased from <u>5/2/86</u> 19 <u>86</u> , to <u>5/3/86</u> 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>5/2/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. |                                                                        |                                                                                                                                 |                                                                                                                               |
| 22b. SIGNATURE<br><u>[Signature]</u>                                                                                                                                                                                                                                                                        | DEGREE<br>MD                                                           | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><u>5/3/86</u>                                                                                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Jonathan D Root MD</u>                                                                                                                                                                                                                                          |                                                                        | 22e. ADDRESS<br><u>Univ of Maryland Hosp 225 Green St</u>                                                                       |                                                                                                                               |

|                                                                   |                         |                                                           |                                                               |
|-------------------------------------------------------------------|-------------------------|-----------------------------------------------------------|---------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial            | 23b. DATE<br>June 4, 86 | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore AA MD |
| 24. FUNERAL DIRECTOR<br>NAME<br>James S. Kirkley, Glen Burnie, MD |                         | 25a. DATE REC'D BY REGISTRAR<br>JUN 12 1986               |                                                               |



202 COLLECTION  
11/11/11

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Thank you for your contribution to the collection.

00-08108

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14142

REG. NO.

|                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |                                                                             |                                                                                                                                                                        |                                                                                          |                                                                                      |                                                                                                 |                                                                                                                            |                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Eulah Lee Shoulders</b>                                                                                                                                                                                                                                                      |  |                                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 30 86</b>                       |                                                                                                                                                                        |                                                                                          | 2b. HOUR<br><b>1 40 PM</b>                                                           |                                                                                                 |                                                                                                                            |                                                                   |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>Caucasian</b>                                                                                                                      |                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 29 08</b>                                                                                                                   |                                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>                                         |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WVA</b>                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                       |                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                    |                                                                                                 |                                                                                                                            |                                                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Gen Hospital</b> |                                                                             |                                                                                                                                                                        |                                                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                                           |                                                                   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>                                                                                                                                                                                                |  |                                                                                                                                                  | 13b. COUNTY<br><b>Baltimore</b>                                             |                                                                                                                                                                        | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                    |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |                                                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Euther Edward Adams</b>                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |                                                                             |                                                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nancy Virginia Sexton</b>            |                                                                                      |                                                                                                 |                                                                                                                            |                                                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                      |  |                                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>151341993</b> |                                                                                                                                                                        | 17. INFORMANT<br>ADDRESS<br><b>Phyllis Dittrich 1328 Tompkins St., Balto., Md. 21229</b> |                                                                                      |                                                                                                 |                                                                                                                            |                                                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b>                                                                                                                                                          |  |                                                                                                                                                  |                                                                             |                                                                                                                                                                        |                                                                                          |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b>                                                             |                                                                   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Complications of Acute Inferior Myocardial Infarct days</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)                                                                              |  |                                                                                                                                                  |                                                                             |                                                                                                                                                                        |                                                                                          |                                                                                      |                                                                                                 |                                                                                                                            |                                                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>Diabetes Mellitus</b>                                                                                                                                                           |  |                                                                                                                                                  |                                                                             |                                                                                                                                                                        |                                                                                          |                                                                                      |                                                                                                 |                                                                                                                            |                                                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |                                                                                                                                                                        |                                                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                |  |                                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5/19 86</b>           |                                                                                                                                                                        |                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                                                                                                 |                                                                                                                            |                                                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                              |  |                                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |                                                                                                                                                                        |                                                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                 |                                                                                                                            |                                                                   |
| 22a. I certify that (1) this hospital attended the deceased from <b>5/19 86</b> to <b>5/30 86</b> , that (1) we lost<br>saw the deceased alive on <b>5/30 86</b> and that (2) our opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death. |  |                                                                                                                                                  |                                                                             |                                                                                                                                                                        |                                                                                          |                                                                                      |                                                                                                 |                                                                                                                            |                                                                   |
| 22b. SIGNATURE<br><b>Leonard M. Lamont</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |                                                                             |                                                                                                                                                                        | DEGREE                                                                                   |                                                                                      | 22c. DATE SIGNED<br><b>5-30-86</b>                                                              |                                                                                                                            | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Leonard M. Lamont</b> |
| 22e. ADDRESS<br><b>3001 S. Hanover St. Baltimore MD 21230</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |                                                                             |                                                                                                                                                                        |                                                                                          |                                                                                      |                                                                                                 |                                                                                                                            |                                                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                                  | 23b. DATE<br><b>6/4/1986</b>                                                |                                                                                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Horner Cemetery</b>                             |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Horner, Lewis Co., W. Va.</b>                  |                                                                                                                            |                                                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Homes</b>                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |                                                                             |                                                                                                                                                                        | 25a. DATE REC'D. BY REGISTRAR                                                            |                                                                                      | 25b. REGISTRAR'S SIGNATURE                                                                      |                                                                                                                            |                                                                   |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing, registration, or removal.

(IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP

JUN 2 1986

CONFIDENTIAL





00-08438

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 1 4 3

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                        |                                                 |                                                                                                                                    |                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Mary Agnes Showe                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>05 31 86 |                                                                                                                                    | 2b. HOUR<br>9:30 A.M. |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>WHITE                                                                                                                                                                                                                                                                       |                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 7 19                                                                                      |                       |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                                                                                                                                                                                                                                                                                         |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                   |                                                 | 8. CITIZEN OF WHAT COUNTRY?<br>U. S.                                                                                               |                       |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                  |  | 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                 |                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Deaton Medical Center |                       |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor                                                                                                                                                                                                                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dept. Store                                                                                                                                                                                                                                       |                                                 | 13a. STREET ADDRESS / ZIP CODE<br>1536 Bryan Ct. (20601)                                                                           |                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Louis Michael Edleman                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary O. Switzer                                                                                                                                                                                                                       |                                                 | 16. SOCIAL SECURITY NO.<br>214-12-4485                                                                                             |                       |  |
| 17. INFORMANT<br>Andrew J. Lanham                                                                                                                                                                                                                                                                                                                  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>metastatic breast cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                 | 19. DATE OF OPERATION                                                                                                              |                       |  |
| 20. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                              |  | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                        |                                                 | 22. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                |                       |  |
| 23. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                            |  | 24. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                              |                                                 | 25. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)                                                     |                       |  |
| 26. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                |  | 27. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                  |                                                 | 28. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                   |                       |  |
| 29. I certify that (I) (this hospital) attended the deceased from <u>5/30</u> <u>1986</u> to <u>5/31</u> <u>1986</u> that (I) (we) last saw the deceased alive on <u>5/30</u> <u>1986</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 30. SIGNATURE<br><u>Greg TAYLOR</u>                                                                                                                                                                                                                                                    |                                                 | 31. DATE SIGNED<br>6/1/86                                                                                                          |                       |  |
| 32. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Greg TAYLOR                                                                                                                                                                                                                                                                                                |  | 33. ADDRESS<br>22. S. Greene St Balt Md                                                                                                                                                                                                                                                |                                                 | 34. DATE SIGNED<br>6/1/86                                                                                                          |                       |  |
| 35. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                 |  | 36. DATE<br>6/3/1986                                                                                                                                                                                                                                                                   |                                                 | 37. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                                                                           |                       |  |
| 38. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn Ph., A.A.Co., Maryland                                                                                                                                                                                                                                                                       |  | 39. FUNERAL DIRECTOR<br>NAME ADDRESS<br>George J. Gonce, 4001 Ritchie Hg., Baltimore, MD.                                                                                                                                                                                              |                                                 | 40. DATE REC'D. BY REGISTRAR<br>JUN 4 1986                                                                                         |                       |  |
| 41. REGISTRAR'S SIGNATURE<br>John Davidson                                                                                                                                                                                                                                                                                                         |  | 42. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                              |                                                 | 43. REGISTRAR'S SIGNATURE                                                                                                          |                       |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked other than 18 shows any injury, or other traumatic event, the medical examiner will be notified.

 BP  
 DHMH - 16 60M 7/84  
 (VRA 15, 4)

(21225)



0-07438

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
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BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14144

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                  |                                                    |                                                                                                                                                             |                                                                                                 |                                                                          |                                                                                     |                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Edward Lawrence Siegle                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>5 21 19 86 |                                                                                                                                                             |                                                                                                 | 2b. HOUR<br>M                                                            |                                                                                     |                                                  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 3 26                                                                                     | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>60 YRS.    | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                                                                                                                     | IF UNDER 24 HRS.                                                                                | 2c. DATE PRONOUNCED DEAD<br>5 21 19 86 6:45                              |                                                                                     |                                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           |                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City AM MD             |                                                                                     |                                                  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Key Medical Center |                                                    |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 13b. COUNTY<br>-----                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                     |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>422 South Oldham St. 21224                        |                                                                                     |                                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward L. Siegle                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                  |                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sadie ?                                                                                                    |                                                                                                 |                                                                          |                                                                                     |                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                                                           |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. 2                                                                |                                                    | 17. INFORMANT ADDRESS<br>Grace M. Siegle 2024 Keblorne Rd. 21222                                                                                            |                                                                                                 |                                                                          |                                                                                     |                                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |                  |                                                                                                                                  |                                                    |                                                                                                                                                             |                                                                                                 |                                                                          |                                                                                     |                                                  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                  |                                                    |                                                                                                                                                             |                                                                                                 |                                                                          |                                                                                     |                                                  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                |                                                    |                                                                                                                                                             |                                                                                                 |                                                                          | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                 |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                       |                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                                                 |                                                                          |                                                                                     |                                                  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                              |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                      |                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                 |                                                                          |                                                                                     |                                                  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |                                                                                                                                  |                                                    |                                                                                                                                                             |                                                                                                 |                                                                          |                                                                                     |                                                  |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | TITLE (SPECIFY)<br>M.D. Assistant                                                                                                |                                                    |                                                                                                                                                             | MEDICAL EXAMINER                                                                                |                                                                          | DATE SIGNED<br>May 21, 86                                                           |                                                  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Gregory R. Kauffman, MD                                                                                                                                                                                                                                                                                                                                                                          |                  | ADDRESS<br>111 Penn Street, Balto, MD 21201                                                                                      |                                                    |                                                                                                                                                             |                                                                                                 |                                                                          |                                                                                     |                                                  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                 |                  | 23b. DATE<br>5-24-86                                                                                                             |                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Belair Memorial Gardens                                                                                               |                                                                                                 |                                                                          | 23d. LOCATION<br>Belair Harbor, Baltimore, MD                                       |                                                  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles S. Zeiler & Son Inc.                                                                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                  |                                                    | ADDRESS<br>6224 Eastern Ave.                                                                                                                                |                                                                                                 | DATE SIGNED<br>MAY 23 1986                                               |                                                                                     |                                                  |

MEDICAL CERTIFICATION

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 14145  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |                                               |                                                                                                                                                             |                     |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John R Sills                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 5 86 |                                                                                                                                                             | 2b. HOUR<br>5:39 AM |                                                                                                                            |  |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>B                                                                                                                         |                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 25 14                                                                                                               |                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  |                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired                                                                                 |                     | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |                                               | 13b. COUNTY                                                                                                                                                 |                     | 13c. CITY OR TOWN<br>Baltimore                                                                                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Garfield Sills                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Orlady Mahrey                                                                                              |                     |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>828-071146                                                                |                                               | 17. INFORMANT<br>Mildred Sills                                                                                                                              |                     | ADDRESS<br>2515 Oakley Ave.                                                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Systemic Lupus Erythematosus</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>30 minutes</u><br><u>10 years</u> |  |                                                                                                                                      |                                               |                                                                                                                                                             |                     |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |                                               |                                                                                                                                                             |                     |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                                                                              |                     |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                     |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/29</u> , 19 <u>86</u> , to <u>5/5</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/5</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                     |  |                                                                                                                                      |                                               |                                                                                                                                                             |                     |                                                                                                                            |  |
| 22b. SIGNATURE<br>Dr. R. Martin                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |                                               | DEGREE<br>MD                                                                                                                                                |                     | 22c. DATE SIGNED<br>5/5/86                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. R. Martin                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |                                               | 22e. ADDRESS<br>Good Samaritan Hospital, Baltimore, MD                                                                                                      |                     |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br>5/10/86                                                                                                                 |                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Nat. Mem. Pk.                                                                                                     |                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel, Md.                                                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>March Funeral Home West 4300 Wabash Avenue                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |                                               | 25a. DATE REC'D. BY REGISTRAR<br>MAY 8 1986                                                                                                                 |                     | 25b. REGISTRAR'S SIGNATURE<br>John Burton                                                                                  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STANDARD TELETYPE

21-12

15 JAN 1977



YAN



00-077361

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14146

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                               |                                                                           |                                                                                                                                                             |  |                                                                                                                            |  |                                                           |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Julia Virginia Silver                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5-21-86                            |                                                                                                                                                             |  | 2b. HOUR<br>8:00 P.M.                                                                                                      |  |                                                           |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>White                                                                                                                              |                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 9 13                                                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS                                                                                  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                        |                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                 |  |                                                           |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital |                                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Tailor                                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Clothing                                                                              |  |                                                           |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY<br>Baltimore                                                                                                                      |                                                                           | 13c. CITY OR TOWN<br>Lansdowne                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS / ZIP CODE<br>2958 Bero Road 21227    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John William Minick                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Florence Rebecca Hamburg |                                                                                                                                                             |  |                                                                                                                            |  |                                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-01-1323                                                                        |                                                                           | 17. INFORMANT<br>ADDRESS<br>Kathryn V. Varner                                                                                                               |  | Same as 13e                                                                                                                |  |                                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                                                                                               |                                                                           |                                                                                                                                                             |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hepes Zoster</u>                                                                                                                                                                                                        |  |                                                                                                                                               |                                                                           |                                                                                                                                                             |  |                                                                                                                            |  |                                                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |                                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                    |                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |                                                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |                                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |                                                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-2-86</u> to <u>5-21-86</u> , that (I) (we) lost<br>saw the deceased alive on <u>5-21-86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) did not view the body after death.                                      |  |                                                                                                                                               |                                                                           |                                                                                                                                                             |  |                                                                                                                            |  |                                                           |  |
| 22b. SIGNATURE<br><u>M. Jelen</u>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                               |                                                                           | DEGREE<br><u>M.D.</u>                                                                                                                                       |  |                                                                                                                            |  | 22c. DATE SIGNED<br><u>5-21-86</u>                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>M. Jelen</u>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                               |                                                                           | 22e. ADDRESS<br><u>3001 S Hanover St Balto MD 21230</u>                                                                                                     |  |                                                                                                                            |  |                                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br>5/24/86                                                                                                                          |                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Pk                                                                                                     |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY<br>Glen Burnie A.A. Md                                                              |  |                                                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                               |                                                                           | ADDRESS<br>4001 Ritchie Hwy Balto Md                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAY 27 1986</u>                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jana Davidson-Gordon</u> |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.



RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These places are marked on the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows only injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                      |  | 86 14147<br>REG. NO.                                                                                                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ESTELLE L. Simms</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                      |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>05 12 86</b>                                                                                                         |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>BLK</b>                                                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>05 7 93</b>                                                                                                           |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SETON HILL MANOR</b>                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. City</b> MD.                                                                                              |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                          |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William Gray</b>                                                                                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Jenny</b>                                                                                           |  |                                                                                                                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br><b>217-015776</b>                                                                                                        |  | 17. INFORMANT ADDRESS<br><b>Julius Simms 12604 N. Point Lane Laurel, MD</b>                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic Breast Carcinomatosis (L)</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>24 mos.</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  |                                                                                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min.</b>                                                                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                    |  |                                                                                                                                                      |  |                                                                                                                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)                                                                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                            |  |                                                                                                                                                      |  |                                                                                                                                                             |  |
| 22b. SIGNATURE<br><b>Jaime Punzalan</b>                                                                                                                                                                                                                                                                                                                                                                |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/13/86</b>                                                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAIME PUNZALAN</b>                                                                                                                                                                                                                                                                                                                                         |  | 22e. ADDRESS<br><b>5214 Harford Rd. Bkto. 21214</b>                                                                                                  |  |                                                                                                                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><b>5-16-86</b>                                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>                                                                                          |  |
| 23d. LOCATION CITY OR TOWN<br><b>Arbutus</b>                                                                                                                                                                                                                                                                                                                                                           |  | COUNTY<br><b>Maryland</b>                                                                                                                            |  | STATE                                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Bailey Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                |  | ADDRESS<br><b>1348 N. Calhoun St. 21217</b>                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 10 1986</b>                                                                                                         |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>James H. ...</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                      |  |                                                                                                                                                             |  |

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ENCLOSURE

WITNESS

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UNITED STATES

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UNITED STATES



00-06136

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by this funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with vital records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a medical examination must be held.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |  |                                                                     |  | 86 14148                       |      |                                              |          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|---------------------------------------------------------------------|--|--------------------------------|------|----------------------------------------------|----------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                     |  | REG. NO.                                                                                               |  |                                                                                                                                                          |  |                                                                |  |                                                                     |  |                                |      |                                              |          |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                           |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                   |  | LAST                                                           |  | 2a. DATE OF DEATH                                                   |  | MONTH                          | DAY  | YEAR                                         | 2b. HOUR |
| Joseph                                                                                                                                                                                                                                                                                     |  | Simpkins                                                                                               |  | Jr.                                                                                                                                                      |  |                                                                |  | 05                                                                  |  | 06                             | 1986 | 31                                           | PM       |
| 3. SEX                                                                                                                                                                                                                                                                                     |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | IF UNDER 1 YEAR                                                     |  | IF UNDER 24 HRS                |      |                                              |          |
| Male                                                                                                                                                                                                                                                                                       |  | Black                                                                                                  |  | 01 23 45                                                                                                                                                 |  | 41 YRS                                                         |  | MONTHS                                                              |  | DAYS                           |      | HOURS MIN.                                   |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN)                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |                                                                     |  |                                |      |                                              |          |
| Maryland                                                                                                                                                                                                                                                                                   |  | USA                                                                                                    |  |                                                                                                                                                          |  | Baltimore City                                                 |  |                                                                     |  |                                |      | MD.                                          |          |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |                                                                     |  |                                |      |                                              |          |
| Baltimore                                                                                                                                                                                                                                                                                  |  | Booth Balt Gen Hosp                                                                                    |  | none                                                                                                                                                     |  |                                                                |  |                                                                     |  |                                |      |                                              |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                               |  | 13b. STATE                                                                                             |  | 13c. COUNTY                                                                                                                                              |  | 13d. CITY OR TOWN                                              |  | 13e. INSIDE CITY LIMITS?                                            |  | 13f. STREET ADDRESS / ZIP CODE |      |                                              |          |
| MD                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |  | Baltimore                                                      |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 21025                          |      | 937 - Seagull Ave                            |          |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME                                                                               |  |                                                                                                                                                          |  |                                                                |  |                                                                     |  |                                |      |                                              |          |
| Joseph                                                                                                                                                                                                                                                                                     |  | Ella                                                                                                   |  |                                                                                                                                                          |  |                                                                |  |                                                                     |  |                                |      | Bailey                                       |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                        |  |                                                                     |  |                                |      |                                              |          |
| NO                                                                                                                                                                                                                                                                                         |  | 219404415                                                                                              |  | Joseph Simpkins Sr.                                                                                                                                      |  | 2036 Kennedy                                                   |  |                                                                     |  |                                |      |                                              |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                      |  | IMMEDIATE CAUSE (a)                                                                                    |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                           |  | DUE TO, OR AS A CONSEQUENCE OF                                 |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | DUE TO, OR AS A CONSEQUENCE OF |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| Cardiopulmonary Arrest. 20                                                                                                                                                                                                                                                                 |  |                                                                                                        |  | Pulmonary Abscess, Sepsis                                                                                                                                |  | Liver Disease, Chronic                                         |  |                                                                     |  |                                |      |                                              |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |  |                                                                     |  |                                |      |                                              |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |  |                                                                     |  |                                |      |                                              |          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                                                     |  |                                |      |                                              |          |
|                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                                                     |  |                                |      |                                              |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                         |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                                                                |  |                                                                     |  |                                |      |                                              |          |
|                                                                                                                                                                                                                                                                                            |  | HOUR A.M. MONTH DAY YEAR                                                                               |  |                                                                                                                                                          |  |                                                                |  |                                                                     |  |                                |      |                                              |          |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION                                                                                                                                            |  | CITY OR TOWN                                                   |  | COUNTY                                                              |  | STATE                          |      |                                              |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |  |                                                                     |  |                                |      |                                              |          |
| 22a. I certify that on this hospital attended the deceased from May 02, 1986, to May 06, 1986, that he was last seen alive on May 06, 1986, and that in my opinion death occurred on the date and hour and from the causes stated above (do not delete) (do not view the body after death) |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |  |                                                                     |  |                                |      |                                              |          |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                             |  | DEGREE                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED                                               |  |                                                                     |  |                                |      |                                              |          |
| J. G. Griffin, MD                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  | 05/06/86                                                       |  |                                                                     |  |                                |      |                                              |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                      |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                |  |                                                                     |  |                                |      |                                              |          |
| J. G. Griffin, MD                                                                                                                                                                                                                                                                          |  | 3001 S. Hanover St.                                                                                    |  |                                                                                                                                                          |  |                                                                |  |                                                                     |  |                                |      |                                              |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                  |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION                                                  |  | CITY OR TOWN                                                        |  | COUNTY                         |      | STATE                                        |          |
| BURIAL                                                                                                                                                                                                                                                                                     |  | 5-10-86                                                                                                |  | CEDAR HILL                                                                                                                                               |  | ANNE ARUNDEL                                                   |  |                                                                     |  |                                |      | MD.                                          |          |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |  |                                                                |  |                                                                     |  |                                |      |                                              |          |
| WM. C. MARCH F/H INC. 1101 E. NORTH AVE.                                                                                                                                                                                                                                                   |  | MAY 9 1986                                                                                             |  | Julia Davidson                                                                                                                                           |  |                                                                |  |                                                                     |  |                                |      |                                              |          |

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 14149  
REG. NO.

|                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DR. I LEE SINGER                                                                                                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5-9-86                                                                                                                                                                                                                                                                                                                 |  | 2b. HOUR<br>4:30 PM                                                                                                                                                   |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                      |  | 4. RACE<br>WHITE                                                                                                                                                                                                                                                                                                                                              |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12-5-11                                                                                                                         |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS                                                                                                                                                                                                                                                           |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                                                                                                                                                                                                                                                  |  | 8. IF UNDER 72 HRS<br>HOURS MIN.                                                                                                                                      |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                |  | 10. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                           |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                                           |  |
| 12. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                              |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Levendale                                                                                                                                                                                                                                        |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DENTIST                                                                                            |  |
| 15. KIND OF BUSINESS OR INDUSTRY<br>DENTISTRY                                                                                                                                                                                                                                                       |  | 16. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>17a. STATE<br>MARYLAND                                                                                                                                                                                                                                               |  | 17b. COUNTY<br>BALTIMORE                                                                                                                                              |  |
| 17c. CITY OR TOWN<br>BALTIMORE                                                                                                                                                                                                                                                                      |  | 18. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                |  | 19. STREET ADDRESS / ZIP CODE<br>2 STONEHENGE CIR. #21208                                                                                                             |  |
| 20. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BENJAMIN SINGER                                                                                                                                                                                                                                           |  | 21. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BESSIE AZEROFF                                                                                                                                                                                                                                                                                               |  | 22. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br>YES WWII-NAVY                                                                           |  |
| 23. SOCIAL SECURITY NO.<br>212-01-4081                                                                                                                                                                                                                                                              |  | 24. INFORMANT<br>MRS. JEANNE SINGER                                                                                                                                                                                                                                                                                                                           |  | 25. ADDRESS<br>2 STONEHENGE CIR. BALTO., MD 21208                                                                                                                     |  |
| 26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RENAL CELL CARCINOMA 2</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>MULTIPLE METASTASES</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>SMALL BOWEL OBSTRUCTION</u> |  |                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>SMALL BOWEL OBSTRUCTION</u>                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                       |  |
| 27a. DATE OF OPERATION                                                                                                                                                                                                                                                                              |  | 27b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                              |  | 27c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                  |  |
| 27d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                          |  | 28a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          |  | 28b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                            |  |
| 28c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                                                                                                                                                      |  | 29a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                     |  | 29b. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)                                                                                                    |  |
| 29c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                   |  | 30. I certify that (I) (this hospital) attended the deceased from <u>4-11</u> , 19 <u>86</u> , to <u>5-9</u> , 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>5-9</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  | 31. SIGNATURE<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 32. DATE SIGNED<br>5-9-86                                                                                                                                                                                                                                                                           |  | 33. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. J. Loo                                                                                                                                                                                                                                                                                                             |  | 34. ADDRESS<br>2434 W Belvedere Ave BALTIMORE 21215                                                                                                                   |  |
| 35. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                  |  | 36. DATE<br>MAY 11, 1986                                                                                                                                                                                                                                                                                                                                      |  | 37. NAME OF CEMETERY OR CREMATORY<br>AITZ CHAIM                                                                                                                       |  |
| 38. LOCATION<br>BALTIMORE                                                                                                                                                                                                                                                                           |  | 39. COUNTY<br>MARYLAND                                                                                                                                                                                                                                                                                                                                        |  | 40. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS. INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215                                                              |  |
| 41. DATE REC'D. BY REGISTRAR<br>MAY 15 1986                                                                                                                                                                                                                                                         |  | 42. REGISTRAR'S SIGNATURE<br>Julia Davidson-Appel                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                       |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. A medical examination may be required at any time. IMPORTANT: If item 27 is marked or item 18 shows any injury, or other traumatic event, a medical examination may be required at any time.

12020-00

PO% COLLECTED





-07955

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 1 5 0  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                         |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ROBERT SIZEMORE                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 19, 1986                           |                                                                                                 | 2b. HOUR<br>02:10 <sup>M</sup>                                                                                             |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                               | 4. RACE<br>white                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 5, 1910                                                                                                          |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS                                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kentucky                                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Labor     | 12b. KIND OF BUSINESS OR INDUSTRY<br>construction                                               |                                                                                                                            |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         | 13b. COUNTY<br>A.A. Co.                                                                                                                                     | 13c. CITY OR TOWN<br>Pasadena                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Madison Sizemore                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ollie Walker                                                                                               |                                                                               | 13e. STREET ADDRESS / ZIP CODE<br>754 203Rd St. 21122                                           |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                                   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>---                                                                          | 17. INFORMANT<br>Robert Sizemore                                                                                                                            |                                                                               | ADDRESS<br>920 Crigger Rd.<br>Gambrells, Md. 21054                                              |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                         |                                                                                                                                                             |                                                                               |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>25 minutes</u><br><u>10 days</u>                                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                       |                                                                                                                                         |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |                                                                                                 |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                 |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                                                                 |                                                                                                                            |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>5/19/86</u> 19 <u>86</u> , to <u>5/19</u> 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>5/19/86</u> 19 <u>86</u> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.                  |                                                                                                                                         |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><u>Raymond DuBois</u>                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                         | DEGREE<br><u>MD</u>                                                                                                                                         |                                                                               | 22c. DATE SIGNED<br><u>5/19/86</u>                                                              |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>RAYMOND DuBois</u>                                                                                                                                                                                                                                                                                                               |                                                                                                                                         | 22e. ADDRESS<br><u>The Johns Hopkins Hospital</u><br>600 N WOLFE ST BALTO MD 21205                                                                          |                                                                               |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                          | 23b. DATE<br>5/22/86                                                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Poplar Springs                                                                                                        |                                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Poplar Springs, Md.                               |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hardesty Funeral Home Ann. Md. 21401                                                                                                                                                                                                                                                                                                         |                                                                                                                                         | 12 Ridgely Ave.<br>ADDRESS                                                                                                                                  |                                                                               | 25a. DATE REC'D BY REGISTRAR<br>MAY 28 1986                                                     |                                                                                                                            |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be retained by the hospital or attending physician. It should be detached for use as the burial permit. Then please move to appropriate pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please move to appropriate pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. The detached permit is carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

14151

|                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             |                                                      |                                                                                                                                                             |                                     |                                                                                        |  |                                                                                                                               |  |                                                                                                 |  |                                                                        |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JAMES L. SLATER</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 9 86</b> |                                                                                                                                                             | 2b. HOUR<br><b>4<sup>00</sup></b> M |                                                                                        |  |                                                                                                                               |  |                                                                                                 |  |                                                                        |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>BLACK</b>                                                                                                                     |                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 9 22</b>                                                                                                         |                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                      |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>                                                                |  | 8. IF UNDER 74 HRS<br>HOURS MIN.<br><b>0 0</b>                                                  |  |                                                                        |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  |                                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                      |  |                                                                                                                               |  |                                                                                                 |  |                                                                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3615 W. Forest Park Ave</b> |                                                      |                                                                                                                                                             |                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Brick layer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |  |                                                                                                 |  |                                                                        |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                             |                                                      |                                                                                                                                                             |                                     | 13b. COUNTY                                                                            |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3615 W. Forest Park Ave 21216</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Mark Slater</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                             |                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Georganna Spain</b>                                                                                     |                                     |                                                                                        |  |                                                                                                                               |  |                                                                                                 |  |                                                                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>251-16-8020</b>                                                                                              |                                                      | 17. INFORMANT ADDRESS<br><b>Dorothy Slater 3615 W. Forest Park</b>                                                                                          |                                     |                                                                                        |  |                                                                                                                               |  |                                                                                                 |  |                                                                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>adenocarcinoma of the lung.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1982</b>                                                                       |  |                                                                                                                                             |                                                      |                                                                                                                                                             |                                     |                                                                                        |  |                                                                                                                               |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 MIN</b>                                |  |                                                                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>                                                                                                                                                                                                                        |  |                                                                                                                                             |                                                      |                                                                                                                                                             |                                     |                                                                                        |  |                                                                                                                               |  |                                                                                                 |  |                                                                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |                                                      |                                                                                                                                                             |                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                 |  |                                                                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                           |                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                     |                                                                                        |  |                                                                                                                               |  |                                                                                                 |  |                                                                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                     |                                                                                        |  |                                                                                                                               |  |                                                                                                 |  |                                                                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/20</b> , 19 <b>85</b> , to <b>5/9</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/9</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                             |                                                      |                                                                                                                                                             |                                     |                                                                                        |  |                                                                                                                               |  |                                                                                                 |  |                                                                        |  |
| 22b. SIGNATURE<br><b>Dorothy A Snow MD</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             |                                                      | DEGREE<br><b>MD</b>                                                                                                                                         |                                     |                                                                                        |  | 22c. DATE SIGNED                                                                                                              |  |                                                                                                 |  |                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dorothy A Snow MD</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |                                                      | 22e. ADDRESS<br><b>3615 W. Forest Park Ave Baltimore MD</b>                                                                                                 |                                     |                                                                                        |  |                                                                                                                               |  |                                                                                                 |  |                                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><b>5/16/86</b>                                                                                                                 |                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Vet</b>                                                                                            |                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills MD</b>                   |  |                                                                                                                               |  |                                                                                                 |  |                                                                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>North Funeral Home West 4300 Wabash Avenue</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |                                                      |                                                                                                                                                             |                                     | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 14 1986</b>                                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jana Davidson-Hendall</b>                                                                    |  |                                                                                                 |  |                                                                        |  |

MEDICAL CERTIFICATION

REBIL MOTION PICTURES

THE WALKER



00-08250

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

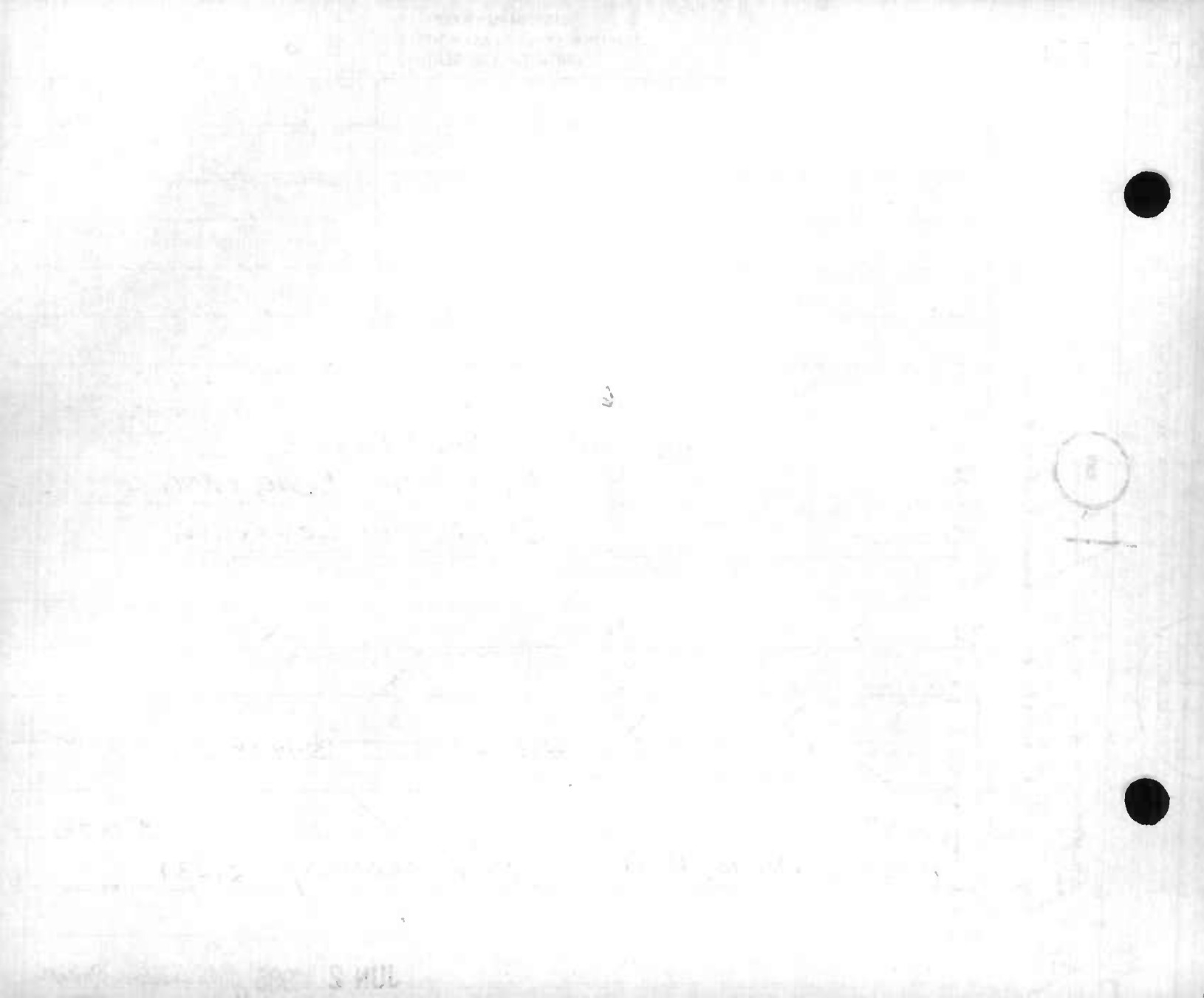
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7 6 1 4 1 5 2                                                                                                                        |  | REG. NO.                                                                                                                                                    |  |                                                                                       |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WARNER SLATER</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 27 86</b>                                 |  | 2b. HOUR<br>A M<br><b>5:00 A</b>                                                                                           |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>Black</b>                                                                                                              |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 30 28</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                        |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1311 N. Port St.</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Refinisher</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Furniture</b>                                                                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |  |                                                                                                                                                             |  | 13b. COUNTY                                                                           |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Horace Slater</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Janie BALL</b>                    |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Unkn.</b>                                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br><b>218-22-7411</b>                                                                                       |  | 17. INFORMANT<br><b>1507 N. Montford Ave. Ms. Mildred Jackson Balto., Md.</b>                                                                               |  |                                                                                       |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>METASTATIC BRAIN TUMOR</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>BILATERAL LUNG CANCER</b><br>(b) <b>LYMPHOBLASTIC LEUKEMIA</b><br>(c) <b>LYMPHOBLASTIC LEUKEMIA</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>X</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>X</b>                                                                         |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>X</b> P.M. <b>19</b>                                                           |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>X</b>                                                               |  |                                                                                       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>X</b>                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>X</b>                                                                                               |  |                                                                                       |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-7-86</b> 19____, to <b>5-24-86</b> 19____, that (I) (we) lost<br>saw the deceased alive on <b>5-24-86</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                      |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Mosbah Dowla, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                      |  | DEGREE<br><b>100 N. Broadway 21231</b>                                                                                                                      |  |                                                                                       |  | 22c. DATE SIGNED<br><b>5-30-86</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mosbah Dowla, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                      |  | 22e. ADDRESS<br><b>100 N. Broadway 21231</b>                                                                                                                |  |                                                                                       |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>6/2/86</b>                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE CEMETERY</b>                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE</b>                        |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WM. C. MARCH FUNERAL HOME</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |  | ADDRESS<br><b>1101 E. NORTH AVE.</b>                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 2 1986</b>                                    |  |                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  |                                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>G. J. Davidson</b>                                   |  |                                                                                                                            |  |

BP





00-08335

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

DHMH - 16 60M 7-84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                                                            |                                                                                                                                                                     |                                                                               |                                                                                       |                                                                     |                                                                                                                            | 8 6                                                            |                                                                          | 1 4 1 5 3 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------------------------------------------------------------------|-----------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                                                            |                                                                                                                                                                     |                                                                               |                                                                                       |                                                                     |                                                                                                                            | REG. NO.                                                       |                                                                          |           |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mozella Small</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 29, 1986</b>                                                                                                          |                                                                               |                                                                                       |                                                                     |                                                                                                                            | 2b. HOUR<br><b>7:20 P<sub>M</sub></b>                          |                                                                          |           |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4 RACE<br><b>Black</b>                                                                                                                        |                                                                                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 23 07</b>                                                                                                       |                                                                                                                                                                     |                                                                               | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS                                       |                                                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                                                |                                                                          |           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |                                                                                                                                   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                                     |                                                                               | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                      |                                                                     |                                                                                                                            |                                                                |                                                                          |           |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MARYLAND GENERAL HOSPITAL</b> |                                                                                                                                   |                                                                                                                                                            |                                                                                                                                                                     |                                                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unemployed</b> |                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                                |                                                                          |           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                                                            | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                                     |                                                                               | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                 |                                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                                | 13e. STREET ADDRESS / ZIP CODE<br><b>501 Dolphin St. Apt. 1515 21217</b> |           |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Johnnie Payne</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Low Roberts</b>                                                                                                 |                                                                               |                                                                                       |                                                                     |                                                                                                                            |                                                                |                                                                          |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>215-16-0235</b>                                                                                                |                                                                                                                                   | 17. INFORMANT<br>ADDRESS<br><b>Olivia Payne 501 Dolphin St. Apt. 1515</b>                                                                                  |                                                                                                                                                                     |                                                                               |                                                                                       |                                                                     |                                                                                                                            |                                                                |                                                                          |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Severe Congestive Heart Failure</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                                                            |                                                                                                                                                                     |                                                                               |                                                                                       |                                                                     |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Month</b> |                                                                          |           |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Coronary Artery Disease</b> Years<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypertension</b> Years                                                                                                                                                                                                 |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                                                            |                                                                                                                                                                     |                                                                               |                                                                                       |                                                                     |                                                                                                                            |                                                                |                                                                          |           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Chronic Renal Failure, Sepsis, Peripheral Vascular Disease</b>                                                                                                                                                                                                                                           |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                                                            |                                                                                                                                                                     |                                                                               |                                                                                       |                                                                     |                                                                                                                            |                                                                |                                                                          |           |  |
| 19a. DATE OF OPERATION<br><b>5/1/86</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Gangrene Right Lower Extremity</b><br><b>Gangrene Left Foot and Sepsis</b> |                                                                                                                                                            |                                                                                                                                                                     |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                |                                                                          |           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                        |  |                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                      |                                                                                                                                                            |                                                                                                                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                                                                       |                                                                     |                                                                                                                            |                                                                |                                                                          |           |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM, ETC.)                                                               |                                                                                                                                                            |                                                                                                                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                                                       |                                                                     |                                                                                                                            |                                                                |                                                                          |           |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 21, 1986</b> to <b>May 29, 1986</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 29, 1986</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <del>XXXX</del> view the body after death. |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                                                            |                                                                                                                                                                     |                                                                               |                                                                                       |                                                                     |                                                                                                                            |                                                                |                                                                          |           |  |
| 22b. SIGNATURE<br><b>Timothy J. Low</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                                                            | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                               |                                                                                       |                                                                     |                                                                                                                            | 22c. DATE SIGNED<br><b>5/29/86</b>                             |                                                                          |           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Timothy J. Low</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                                                            | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                                                |                                                                               |                                                                                       |                                                                     |                                                                                                                            |                                                                |                                                                          |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               | 23b. DATE<br><b>6/4/86</b>                                                                                                        |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cemetery</b>                                                                                                  |                                                                               |                                                                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |                                                                                                                            |                                                                |                                                                          |           |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>March Funeral Homes 1101 East North Avenue</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 3 1986</b>                                                                                                                  |                                                                               | 25b. REGISTRAR'S SIGNATURE<br><b>Juan Davidson</b>                                    |                                                                     |                                                                                                                            |                                                                |                                                                          |           |  |

MEDICAL CERTIFICATION





00-06255

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

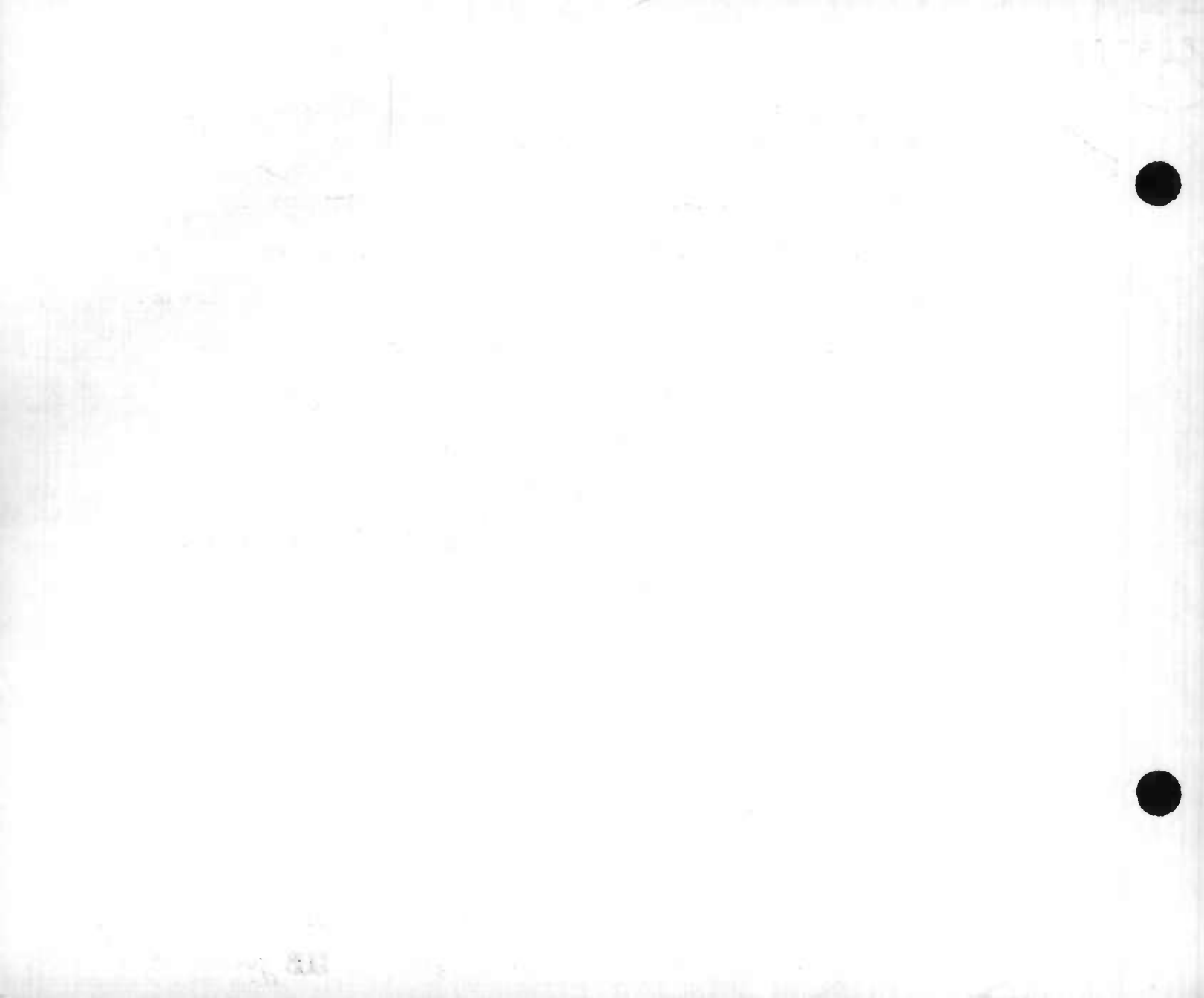
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 1 5 4  
REG. NO.1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                      |                                                                                                                                                  |                                                                               |                                                                                |                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joan B. Smigal                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                      |                                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 11, 1986                           |                                                                                | 2b. HOUR<br>M                                                    |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>white                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12/ 31/ 29                                                                                                 |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |                                                                  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5961 Western Park Drive |                                                                                                                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own home                    |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      |                                                                                                                                                  | 13b. COUNTY<br>Baltimore                                                      | 13c. CITY OR TOWN<br>City                                                      |                                                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Olen Orenduff                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                      |                                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Thelma Shrout                |                                                                                |                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>n/a                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>n/a                                                                                   |                                                                               | 17. INFORMANT<br>ADDRESS<br>Cynthia Koska 3636 Stansbury Mill 21131            |                                                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>constrictions</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>alcoholism with liver failure</u><br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>liver failure</u> |                                                                                                                                      |                                                                                                                                                  |                                                                               |                                                                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                   |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                       |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |                                                                  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                           |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                   |                                                                                                                                      |                                                                                                                                                  |                                                                               |                                                                                |                                                                  |
| 22b. SIGNATURE<br><u>Gerard M. Woel</u> MD                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      |                                                                                                                                                  |                                                                               | 22c. DATE SIGNED<br>May 12, 1986                                               |                                                                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GERARD M WOEL                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      |                                                                                                                                                  |                                                                               | 22e. ADDRESS<br>3315 Pinkney Road                                              |                                                                  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                      | 23b. DATE<br>5/12/86                                                                                                                             |                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory                       |                                                                  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Balto Md.                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                      | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ambrose Inc. 1328 Sulphur Spring Rd.                                                                     |                                                                               |                                                                                |                                                                  |
| 25a. DATE REC'D. BY REGISTRAR<br>MAY 12 1986                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                      |                                                                                                                                                  |                                                                               | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson</u>                            |                                                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.



00-06189

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 4 1 5 5

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                    |                                                                                                                                                             |                                                                                            |                                                                                                                       |                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALBERT SMITH</b>                                                                                                                                                                                                                                                                                                     |                                                                                                                                    |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>8</b> YEAR <b>86</b>                            |                                                                                                                       | 2b. HOUR<br><b>4<sup>PM</sup></b>                                                                                          |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br><b>Black</b>                                                                                                            | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>25</b> YEAR <b>35</b>                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b>                                               | 7. IF UNDER 1 YEAR<br>MONTHS <b>50</b> DAYS <b>50</b> HOURS <b>50</b> MIN.                                            |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                          |                                                                                                                       |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sanitation Dept</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>City</b>                                                                      |                                                                                                                            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                  |                                                                                                                                    | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       | 13e. STREET ADDRESS / ZIP CODE<br><b>626 Allendale Street/21229</b>                                                        |
| 14. FATHER'S NAME<br>FIRST <b>Arthur</b> MIDDLE <b>Fogle</b> LAST <b>Fogle</b>                                                                                                                                                                                                                                                                              |                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Alberta</b> MIDDLE <b>Long</b> LAST <b>Long</b>                                                                        |                                                                                            |                                                                                                                       |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                              |                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br><b>219-32-4350</b>                                                                                                              |                                                                                            | 17. INFORMANT ADDRESS<br><b>Marion Hargrove 626 Allendale St. 21229</b>                                               |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Hypercalcemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Squamous Cell Cancer of Tongue</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1-1/2 years</b>                                                             |                                                                                                                                    |                                                                                                                                                             |                                                                                            |                                                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b>                                                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>                                                                                                                                                                                                                  |                                                                                                                                    |                                                                                                                                                             |                                                                                            |                                                                                                                       |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                    |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR <b>A.M.</b> MONTH <b>5</b> DAY <b>8</b> YEAR <b>19</b><br><b>P.M.</b>                                                           |                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                                        |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                              |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                            | 21f. LOCATION<br>STREET <b>301 St. Paul Pl.</b> CITY OR TOWN <b>Baltimore City</b> COUNTY <b>Md.</b> STATE <b>Md.</b> |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/8</b> , 19 <b>86</b> to <b>5/8</b> , 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>5/8</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                    |                                                                                                                                                             |                                                                                            |                                                                                                                       |                                                                                                                            |
| 22b. SIGNATURE<br><b>Robert C. Greenwell Jr MD</b>                                                                                                                                                                                                                                                                                                          |                                                                                                                                    |                                                                                                                                                             |                                                                                            | 22c. DATE SIGNED<br><b>5/8/86</b>                                                                                     |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT C. Greenwell Jr MD</b>                                                                                                                                                                                                                                                                                   |                                                                                                                                    |                                                                                                                                                             |                                                                                            | 22e. ADDRESS<br><b>301 St. Paul Pl. Baltimore MD</b>                                                                  |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                               | 23b. DATE<br><b>5-13-86</b>                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>                                                                                             | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore City</b> COUNTY <b>Md.</b> STATE <b>Md.</b>     |                                                                                                                       |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME <b>Marshall W. Jones, Jr. FH 4101 Edmondson Ave.</b> 21229                                                                                                                                                                                                                                                                     |                                                                                                                                    |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 24 1986</b>                                        |                                                                                                                       |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                    |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                           |                                                                                                                       |                                                                                                                            |

BP

ALBERT

WILLIAM

Male

Male

12-22-3

20

Married

U.S.A.

X

Religious City

Religious

Religious

Religious City

Married

Religious

X

Religious City

Religious

Religious

Religious

Religious

No

210-32-330

Religious City

Religious

1-13-0

Religious City

Religious City

210

Religious City

00-07731

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 1 5 6

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                    |                                                                        |                                                                                                                                                             |                                       |                                                                                                                                            |                                                                                                 |                                                                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>BENJAMIN E. SMITH.</b>                                                                                                                                                                                                                                                            |  |                                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05 21 86</b>                 |                                                                                                                                                             |                                       | 2b. HOUR<br><b>12<sup>15</sup> A</b> M                                                                                                     |                                                                                                 |                                                                                                                               |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>WHITE</b>                                                                                                                            |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 13 21</b>                                                                                                        |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                                                                                          |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNA.</b>                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                                       |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                          |                                                                                                 |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GEN. HOSPITAL.</b> |                                                                        |                                                                                                                                                             |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Stationary Engineer</b>                                             |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Paper Cup Factory</b>                                                                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>                                                                                                                                                                                                                               |  |                                                                                                                                                    | 13b. COUNTY<br><b>BALTIMORE</b>                                        |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>BALTIMORE</b> |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK SMITH</b>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NELLIE MELLOTT</b> |                                                                                                                                                             |                                       | 13e. STREET ADDRESS / ZIP CODE<br><b>520 ARCAN AVE. 21225</b>                                                                              |                                                                                                 |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OF DATES)<br><b>WW II 184164 024.</b>                                                               |                                                                        | 17. INFORMANT<br><b>Ruth V. Smith</b>                                                                                                                       |                                       | ADDRESS<br><b>Same as 13e</b>                                                                                                              |                                                                                                 |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Squamous cell Carcinoma of lungs.</b>                                          |  |                                                                                                                                                    |                                                                        |                                                                                                                                                             |                                       |                                                                                                                                            |                                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>                                                                                                                                                                                                     |  |                                                                                                                                                    |                                                                        |                                                                                                                                                             |                                       |                                                                                                                                            |                                                                                                 |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                   |                                                                        |                                                                                                                                                             |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                  |                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                       |                                                                                                                                            |                                                                                                 |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                             |                                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                       |                                                                                                                                            |                                                                                                 |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/18/86</b> 19____, to <b>5/21/86</b> 19____, that (I) (we) last saw the deceased alive on <b>5/21/86</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                    |                                                                        |                                                                                                                                                             |                                       |                                                                                                                                            |                                                                                                 |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>George S. Acaredo Vilis</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                    |                                                                        | DEGREE<br><b>MD</b>                                                                                                                                         |                                       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>5/21/86</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George S. Acaredo Vilis</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    |                                                                        | 22e. ADDRESS<br><b>3001 S. Hanover St. Balto Md.</b>                                                                                                        |                                       |                                                                                                                                            |                                                                                                 |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><b>5/23/86</b>                                                                                                                        |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Park</b>                                                                                          |                                       | 23d. LOCATION<br><b>Baltimore Howard Md</b>                                                                                                |                                                                                                 |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                    |                                                                        | ADDRESS<br><b>4001 Ritchie Hwy Balto Md</b>                                                                                                                 |                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 27 1986</b>                                                                                        |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>June Harrison Gonce</b>                                                                      |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





00-08545

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                   |  | REG. NO. 86 14157                                                                                                                                           |  |                                                                                                                                            |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>DAISY M. (T.) SMITH                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 31, 1986                                                                                                         |  |                                                                                                                                            |  | 2b. HOUR<br>10:25AM                                                                                                        |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br>Black                                                                                                                  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 1 24                                                                                                                |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>62 YRS.                                                                                               |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                                                                                |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOME HOSPITAL |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                   |  | 13b. COUNTY                                                                                                                                                 |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS / ZIP CODE<br>2221 E. Jefferson St. 21205                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Tucker                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice Stewart                                                                             |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>224-22-4805                                                            |  | 17. INFORMANT<br>ADDRESS<br>Jean Smith 6834 Sturbridge Drive                                                                                                |  |                                                                                                                                            |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC <del>XXX</del> ASYSTOLE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC UTERINE CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                   |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                                            |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>MAY 21</u> 19 <u>86</u> , to <u>MAY 31</u> 19 <u>86</u> , that (I) <u>we</u> lost saw the deceased alive on <u>MAY 31</u> 19 <u>86</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) <u>did not</u> view the body after death.                |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22a. SIGNATURE<br><u>David H. Madoff</u>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  | DEGREE<br>Ph.D., MD.                                                                                                                                        |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>MAY 31, 1986                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID H. MADOFF, PH.D., MD.                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                   |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>BALTIMORE, MARYLAND 21231                                                                                    |  |                                                                                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br>6/6/86                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Baltimore, Md.                                                                                     |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>March F/H</u>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                   |  | ADDRESS<br><u>1001 E. North Ave</u>                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 5 1986                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                           |  |

STATE OF TEXAS  
COUNTY OF DALLAS  
CITY OF DALLAS

00-00000

THE STATE OF TEXAS

RECEIVED  
JAN 10 1968  
FBI - DALLAS



1968 JAN 10

1968 JAN 10

0-05542

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 1 5 8  
REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                          |  |                                                                                                                                             |                                                                     |                                                                                                                                                             |                                                                          |                                                                                    |                                                                                                 |                                                                  |                                                                           |  |
|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ETHEL SMITH</b>                                                                |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/2/86</b>                |                                                                                                                                                             |                                                                          | 2b. HOUR<br><b>200</b> M                                                           |                                                                                                 |                                                                  |                                                                           |  |
| 3 SEX<br><b>female</b>                                                                                                   |  | 4 RACE<br><b>Black</b>                                                                                                                      |                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 15 04</b>                                                                                                        |                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>                                       |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  |                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> City MD.                  |                                                                                                 |                                                                  |                                                                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |                                                                     |                                                                                                                                                             |                                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                |                                                                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |  |                                                                                                                                             | 13b. COUNTY<br><b>Baltimore</b>                                     |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                    |                                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                  | 13e. STREET ADDRESS / ZIP CODE<br><b>2838 Edgecomb Circle South 21215</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                                                 |  |                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>     |                                                                                                                                                             |                                                                          |                                                                                    |                                                                                                 |                                                                  |                                                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO OR UNKNOWN)<br><b>NO</b>                                      |  |                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>(IF DATE OF WAR OR DATES)<br><b>N/A</b> |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Ralph Lee 2838 Edgecomb Cir. S. 21215</b> |                                                                                    |                                                                                                 |                                                                  |                                                                           |  |

|                                                                                                                                                           |  |                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe dementia</b>                                                                                              |  |                                                 |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                     |  |                                                 |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **NO**

|                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  |                                                                                                                                            |  |                                                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION<br><b>5/2/86</b>                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Severe dementia</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                               |  |
| 22. I certify that (1) this hospital attended the deceased from <b>5/2/86</b> to <b>5/2/86</b> that (1) (we) last saw the deceased on <b>5/2/86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death, so state.) |  |                                                                            |  |                                                                                                                                            |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Robert Devereaux</b>                                                                                                                                                                                                                                                                           |  | DEGREE<br><b>MD</b>                                                        |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/2/86</b>                                                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT DEVEREAUX, M.D.</b>                                                                                                                                                                                                                                              |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                             |  |                                                                                                                                            |  |                                                                                                                               |  |

|                                                                        |  |                            |  |                                                               |  |                                                                          |  |
|------------------------------------------------------------------------|--|----------------------------|--|---------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>          |  | 23b. DATE<br><b>5/6/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastview Mem. Pk</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Leroy O. Dyett 4600 Liberty Hghts. Ave.</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 5 1986</b>            |  | 25b. REGISTRAR'S SIGNATURE                                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10-10-10

10-10-10

10-10-10

00-07059

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14159

|                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                         |                                                                     |                                                                              |                  |                                                                     |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------|----------------------------------------------|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        | 2a DATE KNOWN OF DEATH                                                                                                                                  |                                                                     | MONTH DAY YEAR                                                               |                  | 2b HOUR                                                             |                                              |
| 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | HARRY GLEN SMITH                                                                                                                                        |                                                                     | 5-17-86                                                                      |                  | 19                                                                  |                                              |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4 RACE                                                                                                 | 5 DATE OF BIRTH                                                                                                                                         | 6 AGE (IN YEARS)                                                    | IF UNDER 1 YR.                                                               | IF UNDER 24 HRS. | 2c DATE PRONOUNCED DEAD                                             | 2d HOUR                                      |
| MALE                                                                                                                                                                                                                                                                                                                                                                                                                                  | BLACK                                                                                                  | DEC. 2, 1924                                                                                                                                            | 62 YRS.                                                             |                                                                              |                  | 5-17-86                                                             | 19                                           |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                              | 7b CITIZEN OF WHAT COUNTRY?                                                                            | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH                                          |                  |                                                                     |                                              |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                              | U.S.A.                                                                                                 |                                                                                                                                                         |                                                                     | Baltimore City MD.                                                           |                  |                                                                     |                                              |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                         |                                                                     | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |                  | 12b KIND OF BUSINESS OR INDUSTRY                                    |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                             | 4612 Manordene Rd. Apt., A                                                                             |                                                                                                                                                         |                                                                     | ALUMINUM                                                                     |                  |                                                                     |                                              |
| 13a STATE                                                                                                                                                                                                                                                                                                                                                                                                                             | 13b COUNTY                                                                                             | 13c CITY OR TOWN                                                                                                                                        | 13d INSIDE CITY LIMITS?                                             | 13e STREET ADDRESS                                                           |                  |                                                                     |                                              |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                              | N/A                                                                                                    | BALTIMORE                                                                                                                                               | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4612 Manordene Rd. 21229                                                     |                  |                                                                     |                                              |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                         |                                                                     | 15 MOTHER'S MAIDEN NAME                                                      |                  |                                                                     |                                              |
| HARRY G. SMITH, SR.                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                         |                                                                     | EMMA E. CHASE                                                                |                  |                                                                     |                                              |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | 16b SOCIAL SECURITY NO.                                                                                                                                 |                                                                     | 17 INFORMANT ADDRESS                                                         |                  |                                                                     |                                              |
| YES                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        | WWII                                                                                                                                                    |                                                                     | Yvonne Young 4612 Manordene Rd. 21229                                        |                  |                                                                     |                                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                         |                                                                     |                                                                              |                  |                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                         |                                                                     |                                                                              |                  |                                                                     |                                              |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                         |                                                                     |                                                                              |                  |                                                                     |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                         |                                                                     |                                                                              |                  |                                                                     |                                              |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                         |                                                                     |                                                                              |                  |                                                                     |                                              |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                         |                                                                     |                                                                              |                  |                                                                     |                                              |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                         |                                                                     |                                                                              |                  |                                                                     |                                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                         |                                                                     |                                                                              |                  |                                                                     |                                              |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                        |                                                                     |                                                                              |                  | 20 AUTOPSY?                                                         |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                         |                                                                     |                                                                              |                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |                                                                                                        | 21b TIME OF INJURY                                                                                                                                      |                                                                     | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                  |                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | HOUR A.M. MONTH DAY YEAR                                                                                                                                |                                                                     |                                                                              |                  |                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | P.M. 19                                                                                                                                                 |                                                                     |                                                                              |                  |                                                                     |                                              |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |                                                                                                        | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                              |                                                                     | 21f LOCATION                                                                 |                  |                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                         |                                                                     | CITY OR TOWN COUNTY STATE                                                    |                  |                                                                     |                                              |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                                                                                        |                                                                                                                                                         |                                                                     |                                                                              |                  |                                                                     |                                              |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        | TITLE (SPECIFY)                                                                                                                                         |                                                                     | MEDICAL EXAMINER                                                             |                  | DATE SIGNED                                                         |                                              |
| Margarita A. Korell                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        | Assistant                                                                                                                                               |                                                                     |                                                                              |                  | 5-18-86                                                             |                                              |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | 111 Penn Street                                                                                                                                         |                                                                     |                                                                              |                  |                                                                     |                                              |
| Margarita A. Korell M.D.                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                         |                                                                     |                                                                              |                  |                                                                     |                                              |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        | 23b DATE                                                                                                                                                |                                                                     | 23c NAME OF CEMETERY OR CREMATORY                                            |                  | 23d LOCATION                                                        |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | 5/22/86                                                                                                                                                 |                                                                     | Garrison Forest VA                                                           |                  | OWINGS MILLS, Maryland                                              |                                              |
| 24 FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                         |                                                                     | 25a DATE REC'D. BY REGISTRAR                                                 |                  | 25b REGISTRAR'S SIGNATURE                                           |                                              |
| Leroy O. Dyett 4600 Lib. Hgts. Ave.                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                         |                                                                     | MAY 20 1986                                                                  |                  |                                                                     |                                              |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 WESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

Q33BT

Q33BT





00-06114

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                           |  |                                                                                                                           |  | REG. NO. 8 6 1 4 1 6 0                                                                                                                                      |  |                                                                                           |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                           |  |                                                                                                                                                             |  |                                                                                           |                                              |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Harry W. Smith, Sr.                                                                                                                                                                                                                                                                                                      |  |                                                                                                                           |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>MAY 5, 1986                                                                                                             |  | 2b. HOUR<br>12:35P <sub>M</sub>                                                           |                                              |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br>White                                                                                                          |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 31 1897                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>88 YRS.                         |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Streetcar Driver                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>M.T.A.                                               |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                        |  |                                                                                                                           |  |                                                                                                                                                             |  |                                                                                           |                                              |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br>Harford                                                                                                    |  | 13c. CITY OR TOWN<br>Havre de Grace                                                                                                                         |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>         |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Not Known Smith                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Wilhelmina Brenner                                                                                            |  |                                                                                           |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>213-10-1363                                                                                   |  | 17. INFORMANT ADDRESS<br>Pearl E. Smith                                                                                                                     |  | Same as 13e                                                                               |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CANCER RECTOSIGMOID</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                           |  |                                                                                                                                                             |  |                                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATING TO THE IMMEDIATE CAUSE OR CONDITION GIVEN IN PART I (a)<br><b>POST -OP DEHISCENCE CLOSURE WITH DIVERTING PERITONEAL COLOSTOMY FOR RECTOSIG-</b>                                                                                                                                                    |  |                                                                                                                           |  |                                                                                                                                                             |  |                                                                                           |                                              |
| 19a. DATE OF OPERATION<br>MAY 1, 1986                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>WOUND DEHISCENCE                                                      |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, MODERATE OR SEVERE? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)<br>P.M. 19                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                           |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                       |  | 21f. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                     |  |                                                                                           |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 16</u> 19 <u>86</u> to <u>MAY 5</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>MAY 5, 1986</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.           |  |                                                                                                                           |  |                                                                                                                                                             |  |                                                                                           |                                              |
| 22b. SIGNATURE<br><i>Prasad Sompalli M.D.</i>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                           |  | 22c. DATE SIGNED<br>MAY 9 1986                                                                                                                              |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PRASAD SOMPALLI M.D.                             |                                              |
| 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY BALTO., MD. 21231                                                                                                                                                                                                                                                                                               |  |                                                                                                                           |  |                                                                                                                                                             |  |                                                                                           |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br>5/8/1986                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens Of Faith                                                                                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                             |                                              |
| 24. FUNERAL DIRECTOR NAME<br>Duda-Ruck, Inc.                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                           |  | 25a. DATE RECEIVED BY REGISTRAR<br>MAY 9 1986                                                                                                               |  |                                                                                           |                                              |
| 7922 Wise Avenue Dundalk, Maryland 21222                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                           |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                            |  |                                                                                           |                                              |



RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove a duplicate of this certificate from the bottom of the certificate and submit it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified of cause.

00-06518

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                               |  |                                                                                                                                                             |                                                                 |                                                                            |                                  |                                                                                                                            |                                                                                                 |                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                               |  |                                                                                                                                                             |                                                                 |                                                                            |                                  |                                                                                                                            |                                                                                                 | 8 6 1 4 1 6 1                                |  |
| 1. FOR STATE REGISTRAR IRMA R. SMITH                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                               |  |                                                                                                                                                             |                                                                 |                                                                            |                                  |                                                                                                                            |                                                                                                 | REG. NO.                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>IRMA R SMITH                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                               |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>05/13/86                 |                                                                            |                                  | 2b. HOUR<br>2:00pm M                                                                                                       |                                                                                                 |                                              |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4 RACE<br>White                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 25, 1894                                                                                                        |                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.                                 |                                  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |                                                                                                 |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                  |                                  |                                                                                                                            |                                                                                                 |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>ST. AGNES HOSPITAL |  |                                                                                                                                                             |                                                                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                                                              |                                                                                                 |                                              |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                               |  |                                                                                                                                                             | 13b. COUNTY<br>Baltimore                                        |                                                                            | 13c. CITY OR TOWN<br>Catonsville |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Conrad C. Rabbe                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                               |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Louise unknown |                                                                            |                                  |                                                                                                                            |                                                                                                 |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO<br>820-00-0817                                        |  | 17. INFORMANT<br>Elizabeth Smith                                                                                                                            |                                                                 | 17a. ADDRESS<br>Rt. 1 - Box 200<br>Easton, MD. 21601                       |                                  |                                                                                                                            |                                                                                                 |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cerebral ischemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>cardiovascular insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>pulmonary edema, congestive heart failure</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> |  |                                                                               |  |                                                                                                                                                             |                                                                 |                                                                            |                                  |                                                                                                                            |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |                                                                                                                                                             |                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                 |                                                                            |                                  |                                                                                                                            |                                                                                                 |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE                                                                                                  |                                                                 |                                                                            |                                  |                                                                                                                            |                                                                                                 |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                                 |  |                                                                               |  |                                                                                                                                                             |                                                                 |                                                                            |                                  |                                                                                                                            |                                                                                                 |                                              |  |
| 22b. SIGNATURE<br>A. Maculis                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                               |  | DEGREE                                                                                                                                                      |                                                                 |                                                                            |                                  | 22c. DATE SIGNED<br>5/13/86                                                                                                |                                                                                                 |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MACULIS, A.                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                               |  | 22e. ADDRESS<br>St. Agnes Hospital, Baltimore, MD.                                                                                                          |                                                                 |                                                                            |                                  |                                                                                                                            |                                                                                                 |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br>5/16/86                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery                                                                                                     |                                                                 | 23d. LOCATION<br>CITY OR TOWN<br>Woodlawn                                  |                                  | COUNTY<br>Maryland                                                                                                         |                                                                                                 | STATE                                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, MD. 21228                                                                                                                                                                                                                                                                                                                                                       |  |                                                                               |  |                                                                                                                                                             |                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>MAY 14 1986                               |                                  | 25b. REGISTRAR'S SIGNATURE                                                                                                 |                                                                                                 |                                              |  |

5

0-07205

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                             |  | 7 REG. NO.                                                                                             |  | 8 6 1 4 1 6 2                                                                                                                                            |  |                                                                     |  |                                                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                |  |                                                                                                        |  | 2a. DATE OF DEATH                                                                                                                                        |  | MONTH DAY YEAR                                                      |  | 2b. HOUR                                                            |  |
| James SMITH                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | May 20, 1986                                                                                                                                             |  |                                                                     |  | 11:35A <sub>M</sub>                                                 |  |
| 3. SEX                                                                                                                                                                                                                                                                                                             |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR                                                  |  |
| MALE                                                                                                                                                                                                                                                                                                               |  | BLACK                                                                                                  |  | MONTH DAY YEAR<br>5 6 27                                                                                                                                 |  | 59 YRS.                                                             |  | MONTHS DAYS HOURS MIN.                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                                                     |  |
| Maryland                                                                                                                                                                                                                                                                                                           |  | USA                                                                                                    |  |                                                                                                                                                          |  | Baltimore City MD.                                                  |  |                                                                     |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore                                                                                                                                                                                                                                                                                                          |  | Maryland General Hospital                                                                              |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | 13b. COUNTY                                                                                                                                              |  | 13c. CITY OR TOWN                                                   |  | 13d. INSIDE CITY LIMITS?                                            |  |
| Maryland                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  | Baltimore                                                           |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |  | 13e. STREET ADDRESS / ZIP CODE                                      |  |                                                                     |  |
| Louis Smith                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | Helen Richardson                                                                                                                                         |  | 2803 Garrison Blvd. 21216                                           |  |                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                  |  |                                                                                                        |  | 16b. SOCIAL SECURITY NO.                                                                                                                                 |  | 17. INFORMANT ADDRESS                                               |  |                                                                     |  |
| no                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  | n/a                                                                                                                                                      |  | 21215 James Williams 4417 Pall Mall Rd.                             |  |                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| IMMEDIATE CAUSE (a) Sepsis                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |
| (b) Extensive Gangrene of the left leg                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |
| (c) Severe peripheral vascular disease                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |
| Brain stem infarct; Parkinson's disease; hypertension                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                          |  | 20a. AUTOPSY?                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                 |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |                                                                     |  |                                                                     |  |
|                                                                                                                                                                                                                                                                                                                    |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                    |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION                                                                                                                                            |  |                                                                     |  |                                                                     |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                  |  |                                                                                                        |  | STREET CITY OR TOWN COUNTY STATE                                                                                                                         |  |                                                                     |  |                                                                     |  |
| 22a. I certify that (1) this hospital attended the deceased from May 14, 1986, to May 20, 1986, that (1) (we) last saw the deceased alive on May 20, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (do not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | DEGREE                                                                                                                                                   |  |                                                                     |  | 22c. DATE SIGNED                                                    |  |
| Patricia Weber M.D.                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  | 5/20/86                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | 22e. ADDRESS                                                                                                                                             |  |                                                                     |  |                                                                     |  |
| Patricia Weber, M.D.                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | c/o Maryland General Hospital                                                                                                                            |  |                                                                     |  |                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                          |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION                                                       |  |                                                                     |  |
| Burial                                                                                                                                                                                                                                                                                                             |  | 5/24/86                                                                                                |  | King Mem. Park                                                                                                                                           |  | Baltimore, MD                                                       |  |                                                                     |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | 25a. DATE RECEIVED BY REGISTRAR                                                                                                                          |  | 25b. RECEIVED BY REGISTRAR                                          |  |                                                                     |  |
| NAME ADDRESS                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  | MAY 21 1986                                                                                                                                              |  |                                                                     |  |                                                                     |  |
| Leroy O. Dyett 4600 Lib. Hgts. Ave.                                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                     |  |

MEDICAL CERTIFICATION

20110-0



0-06097

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 4 1 6 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |                                                                        |                                                                                                                                                             |                                |                                                                                                                                                 |                                                                                                 |                                                                                                                                                                                                                                                                   |                                                               |                                                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James Chandler Smith Jr.                                                                                                                                                                                                                                                             |  |                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 6 86                          |                                                                                                                                                             |                                | 2b. HOUR<br>11:45 AM                                                                                                                            |                                                                                                 |                                                                                                                                                                                                                                                                   |                                                               |                                                                      |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>Caucasian                                                                                                             |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03-08-37                                                                                                              |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>49 YRS.                                                                                                      |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                                                                                                                                                      |                                                               |                                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                      |                                                                                                 |                                                                                                                                                                                                                                                                   |                                                               |                                                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1520 Jackson Street |                                                                        |                                                                                                                                                             |                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                                                                     |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                 |                                                               |                                                                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                           |  |                                                                                                                                  | 13b. COUNTY                                                            |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore |                                                                                                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                                                                                                                                                   | 13e. STREET ADDRESS / ZIP CODE<br>1520 East Fort Avenue 21230 |                                                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Chandler Smith Sr.                                                                                                                                                                                                                                                          |  |                                                                                                                                  |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Audrey Irene Wilberger                                                                                     |                                |                                                                                                                                                 |                                                                                                 | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                       |                                                               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>3-54-3-56 |  |
| 17. INFORMANT<br>Mary P. Melton                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |                                                                        | ADDRESS<br>1520 Jackson St.<br>Baltimore, Md 21230                                                                                                          |                                |                                                                                                                                                 |                                                                                                 | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-respiratory failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic colon carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF (c) |                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.                                                                                                                                                                                         |  |                                                                                                                                  |                                                                        |                                                                                                                                                             |                                |                                                                                                                                                 |                                                                                                 |                                                                                                                                                                                                                                                                   |                                                               |                                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                        |                                                               |                                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |  |                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                  |                                                                                                 |                                                                                                                                                                                                                                                                   |                                                               |                                                                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                   |  |                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                               |                                                                                                 |                                                                                                                                                                                                                                                                   |                                                               |                                                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                  |                                                                        |                                                                                                                                                             |                                |                                                                                                                                                 |                                                                                                 |                                                                                                                                                                                                                                                                   |                                                               |                                                                      |  |
| 22b. SIGNATURE<br><i>Joseph A. Ciotola</i>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                  | DEGREE<br>M.D.                                                         |                                                                                                                                                             |                                | 22c. DATE SIGNED<br>5/7/86                                                                                                                      |                                                                                                 |                                                                                                                                                                                                                                                                   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joseph A. Ciotola    |                                                                      |  |
| 22e. ADDRESS<br>3350 Wilkens Avenue, Balto Md 21229                                                                                                                                                                                                                                                                         |  |                                                                                                                                  | 22f. ADDRESS                                                           |                                                                                                                                                             |                                | 22g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 |                                                                                                                                                                                                                                                                   | 22h. ADDRESS                                                  |                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                   |  |                                                                                                                                  | 23b. DATE<br>5-7-86                                                    |                                                                                                                                                             |                                | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process                                                                                          |                                                                                                 |                                                                                                                                                                                                                                                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |                                                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Cremation Society of Md Inc. Maryland                                                                                                                                                                                                                                                       |  |                                                                                                                                  | ADDRESS<br>Catonsville                                                 |                                                                                                                                                             |                                | 25a. DATE REC'D. BY REGISTRAR<br>MAY 9 1986                                                                                                     |                                                                                                 |                                                                                                                                                                                                                                                                   | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>            |                                                                      |  |

58337-0



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00-07892

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 1 6 4  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         |                                                         |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Luther Smith</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 25 1986</b> |                                                                                                                                                            |  | 2b. HOUR<br><b>12:40 PM</b>                                                                     |  |                                                                                                                            |  |
| 3 SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 4 RACE<br><b>NEGRO</b>                                                                                                                  |                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05 11 1918</b>                                                                                                    |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>                                                                                               |                                                         | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>                                |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECURE Hospital</b> |                                                         |                                                                                                                                                            |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY                                                                                                                             |                                                         | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2572 W Faye He St 21223</b>                                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ruffin Smith</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Randie Smith</b>                                                                                       |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>240-14-4575</b>                                                                                          |                                                         | 17. INFORMANT<br>ADDRESS<br><b>Alma Smith</b>                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>congestive cardiomyopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                         |                                                         |                                                                                                                                                            |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>                                                                                                                                                                                                                                           |  |                                                                                                                                         |                                                         |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |                                                         |                                                                                                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                       |                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 17, 1986</b> , to <b>May 25, 1986</b> , that (I) (we) lost<br>saw the deceased alive on <b>May 26, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                  |  |                                                                                                                                         |                                                         |                                                                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Donald Blumenthal MD</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |                                                         | DEGREE<br><b>MD</b>                                                                                                                                        |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>May 28, 1986</b>                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald Blumenthal MD</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |                                                         | 22e. ADDRESS<br><b>2000 W. Baltimore St</b>                                                                                                                |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(BY WHOM)<br><b>Brown &amp; Thompson</b>                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>5/27/86</b>                                                                                                             |                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARRISON Forest</b>                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>193 Baltimore City MD</b>                      |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Brown Thompson</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                         |                                                         | ADDRESS<br><b>1713 Balt. St.</b>                                                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 28 1986</b>                                             |  | 25. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>                                                                         |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward the certificate to the State Dept. of Health and Mental Hygiene for filing with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

100% COPIES

ORIGINAL



00-05408

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14165

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                   |                                                                     |     |                                   |          |                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------|-----|-----------------------------------|----------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                           |                                                                                                           | FIRST                                                                                                                                                       | MIDDLE                                                           | LAST                                                                                                                                       | 2a. DATE OF DEATH                 | MONTH                                                               | DAY | YEAR                              | 2b. HOUR | M                                               |
| THEODORE                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           | R.                                                                                                                                                          |                                                                  | SMITH                                                                                                                                      | 5                                 | 1                                                                   | 96  |                                   | 10:30    | A                                               |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                        | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            |                                                                  | 6. AGE (IN YEARS (LAST BIRTHDAY))                                                                                                          |                                   | IF UNDER 1 YEAR                                                     |     | IF UNDER 24 HRS                   |          |                                                 |
| Male                                                                                                                                                                                                                                                                                                                                                          | White                                                                                                     | MONTH DAY YEAR<br>9 9 02                                                                                                                                    |                                                                  | 83 YRS                                                                                                                                     |                                   | MONTHS DAYS                                                         |     | HOURS MIN.                        |          |                                                 |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                       |                                   |                                                                     |     |                                   |          |                                                 |
| Maryland                                                                                                                                                                                                                                                                                                                                                      | USA                                                                                                       |                                                                                                                                                             |                                                                  | Baltimore City MD.                                                                                                                         |                                   |                                                                     |     |                                   |          |                                                 |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                     |     |                                   |          |                                                 |
| Baltimore                                                                                                                                                                                                                                                                                                                                                     | Bon Secours Hospital                                                                                      |                                                                                                                                                             | Superintendent                                                   |                                                                                                                                            | Sanitation Dept.                  |                                                                     |     |                                   |          |                                                 |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           | 13b. COUNTY                                                                                                                                                 |                                                                  | 13c. CITY OR TOWN                                                                                                                          |                                   | 13d. INSIDE CITY LIMITS?                                            |     | 13e. STREET ADDRESS / ZIP CODE    |          |                                                 |
| Maryland                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           | Baltimore                                                                                                                                                   |                                                                  | Relay                                                                                                                                      |                                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |     | 920 Francis Avenue, 21227         |          |                                                 |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | 15. MOTHER'S MAIDEN NAME                                                                                                                                    |                                                                  |                                                                                                                                            |                                   |                                                                     |     |                                   |          |                                                 |
| FIRST MIDDLE LAST<br>UNKNOWN Smith                                                                                                                                                                                                                                                                                                                            |                                                                                                           | FIRST MIDDLE LAST<br>Iva Conley                                                                                                                             |                                                                  |                                                                                                                                            |                                   |                                                                     |     |                                   |          |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                          |                                                                                                           | 16b. SOCIAL SECURITY NO.                                                                                                                                    |                                                                  | 17. INFORMANT ADDRESS                                                                                                                      |                                   |                                                                     |     |                                   |          |                                                 |
| No                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           | 214-16-6540                                                                                                                                                 |                                                                  | Charles C. Smith, 5973 Setter Drive, 21227                                                                                                 |                                   |                                                                     |     |                                   |          |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                   |                                                                     |     |                                   |          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                   |                                                                     |     |                                   |          |                                                 |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PNEUMONIA (R) Lower LOBE</u>                                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                   |                                                                     |     |                                   |          |                                                 |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                   |                                                                     |     |                                   |          |                                                 |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Probably metastatic Carcinoma Lung.</u>                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                   |                                                                     |     |                                   |          |                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                   |                                                                     |     |                                   |          |                                                 |
| <u>(R) PLEURAL EFFUSION.</u>                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                   |                                                                     |     |                                   |          |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                        |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                  | 20a. AUTOPSY?                                                                                                                              |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |     |                                   |          |                                                 |
| NIL                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           | NIL                                                                                                                                                         |                                                                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |     |                                   |          |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                      |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. NA 19                                                                                               |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)                                                              |                                   |                                                                     |     |                                   |          |                                                 |
|                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | NA                                                                                                                                                          |                                                                  | NA                                                                                                                                         |                                   |                                                                     |     |                                   |          |                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                     |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                   |                                                                     |     |                                   |          |                                                 |
|                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |                                                                  | NA                                                                                                                                         |                                   |                                                                     |     |                                   |          |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-29-</u> 19 <u>86</u> , to <u>5-1-</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5-1-</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                   |                                                                     |     |                                   |          |                                                 |
| 22b. SIGNATURE<br><u>Surjit S.</u>                                                                                                                                                                                                                                                                                                                            |                                                                                                           | DEGREE<br><u>MD</u>                                                                                                                                         |                                                                  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   |                                                                     |     | 22c. DATE SIGNED<br><u>5-1-86</u> |          |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>SURJIT S.</u>                                                                                                                                                                                                                                                                                                     |                                                                                                           | 22e. ADDRESS<br><u>JULKA</u>                                                                                                                                |                                                                  | <u>BON SECOURS HOSPITAL.</u>                                                                                                               |                                   |                                                                     |     |                                   |          |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                  |                                                                                                           | 23b. DATE                                                                                                                                                   |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                         |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |     |                                   |          |                                                 |
| Burial                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           | 5/3/86                                                                                                                                                      |                                                                  | Loudon Park Cemetery                                                                                                                       |                                   | Baltimore Maryland                                                  |     |                                   |          |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                  |                                                                                                           | ADDRESS                                                                                                                                                     |                                                                  | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |                                   | 25b. REGISTRAR'S SIGNATURE                                          |     |                                   |          |                                                 |
| Hubbard Funeral Home, Inc.,                                                                                                                                                                                                                                                                                                                                   |                                                                                                           | 21229<br>4107 Wilkens Ave.                                                                                                                                  |                                                                  | MAY 2 1986                                                                                                                                 |                                   | <u>Julia K. [Signature]</u>                                         |     |                                   |          |                                                 |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30% COTTON FIBRE

WATERMARK



00-08231

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be kept with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

|                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |                                                                     |                                                                                                                                                                     |                                                                                             |                                                                                   |                                                                                                                                            |                                                                                                                                    |                          |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                            |  |                                                                                                                                     |                                                                     |                                                                                                                                                                     |                                                                                             |                                                                                   |                                                                                                                                            |                                                                                                                                    |                          | 8614166                                      |  |
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                          |  |                                                                                                                                     |                                                                     |                                                                                                                                                                     |                                                                                             |                                                                                   |                                                                                                                                            |                                                                                                                                    |                          | REG. NO.                                     |  |
| 2a. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> Irene <sup>MIDDLE</sup> TRUMAN <sup>LAST</sup> SMITH                                                                                                                                                                                         |  |                                                                                                                                     |                                                                     |                                                                                                                                                                     | 2b. DATE OF DEATH <sup>MONTH</sup> 5 <sup>DAY</sup> 28 <sup>YEAR</sup> 86                   |                                                                                   |                                                                                                                                            | 2c. HOUR 10 <sup>04</sup> AM                                                                                                       |                          |                                              |  |
| 3. SEX M                                                                                                                                                                                                                                                                                        |  | 4. RACE B                                                                                                                           |                                                                     | 5. DATE OF BIRTH MO 8 / 1 / 1905                                                                                                                                    |                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY) 80                                                |                                                                                                                                            | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                                                         |                          |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                                 |                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.                           |                                                                                                                                            |                                                                                                                                    |                          |                                              |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE CITY                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LOCH RAVEN VETERANS HOSPITAL |                                                                     |                                                                                                                                                                     |                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer             |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY Cement Co.                                                                                       |                          |                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Carroll 13c. CITY OR TOWN Union Bridge                                                                                                                                  |  |                                                                                                                                     |                                                                     |                                                                                                                                                                     | 14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                   | 15. STREET ADDRESS / ZIP CODE 4 Rinehart St. 21791                                                                                         |                                                                                                                                    |                          |                                              |  |
| 16a. FATHER'S NAME <sup>FIRST</sup> Charles <sup>MIDDLE</sup> <sup>LAST</sup> Smith                                                                                                                                                                                                             |  |                                                                                                                                     |                                                                     |                                                                                                                                                                     | 16b. MOTHER'S MAIDEN NAME <sup>FIRST</sup> Rachel <sup>MIDDLE</sup> <sup>LAST</sup> White   |                                                                                   |                                                                                                                                            |                                                                                                                                    |                          |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO. WW II 213-03-1080                                                                                          |                                                                     | 17. INFORMANT ADDRESS Union Bridge, Md. Thelma M. Clark 4 Rinehart St.                                                                                              |                                                                                             |                                                                                   |                                                                                                                                            |                                                                                                                                    |                          |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST                                                                                                                                                |  |                                                                                                                                     |                                                                     |                                                                                                                                                                     |                                                                                             |                                                                                   |                                                                                                                                            |                                                                                                                                    |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) SQUAMOUS CELL CARCINOMA OF LARYNX                                                                                                                           |  |                                                                                                                                     |                                                                     |                                                                                                                                                                     |                                                                                             |                                                                                   |                                                                                                                                            |                                                                                                                                    |                          |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                              |  |                                                                                                                                     |                                                                     |                                                                                                                                                                     |                                                                                             |                                                                                   |                                                                                                                                            |                                                                                                                                    |                          |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0                                                                                                                                                              |  |                                                                                                                                     |                                                                     |                                                                                                                                                                     |                                                                                             |                                                                                   |                                                                                                                                            |                                                                                                                                    |                          |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                          |  |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                                     |                                                                                             | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                              |  |                                                                                                                                     | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |                                                                                                                                                                     |                                                                                             | 21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                                                                                                                                            |                                                                                                                                    |                          |                                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                               |  |                                                                                                                                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                                     |                                                                                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                                            |                                                                                                                                    |                          |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/28 1986 to 5/28 1986 that (I) saw the deceased alive on 5/28 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                     |                                                                     |                                                                                                                                                                     |                                                                                             |                                                                                   |                                                                                                                                            |                                                                                                                                    |                          |                                              |  |
| 22b. SIGNATURE R. Pinos MD                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |                                                                     |                                                                                                                                                                     | DEGREE                                                                                      |                                                                                   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                                    | 22c. DATE SIGNED 5/28/86 |                                              |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) RALPH JOSEPH PINOS                                                                                                                                                                                                                                        |  |                                                                                                                                     |                                                                     |                                                                                                                                                                     | 23b. ADDRESS LRVN                                                                           |                                                                                   |                                                                                                                                            |                                                                                                                                    |                          |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                |  |                                                                                                                                     | 23b. DATE 5/31/1986                                                 |                                                                                                                                                                     | 23c. NAME OF CEMETERY OR CREMATORY Woodville Cem.                                           |                                                                                   |                                                                                                                                            | 23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Md.                                                                              |                          |                                              |  |
| 24. FUNERAL DIRECTOR D. D. Sathyan New Windsor, Md. ADDRESS 310 Church St.                                                                                                                                                                                                                      |  |                                                                                                                                     |                                                                     |                                                                                                                                                                     | 25a. DATE REC'D. BY REGISTRAR JUN 2 1986                                                    |                                                                                   | 25b. REGISTRAR'S SIGNATURE John Davidson-Rendell                                                                                           |                                                                                                                                    |                          |                                              |  |



00-05608

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8614167

|                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                    |                                                                                                                                                             |                    |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>FIRST MIDDLE LAST<br>MATTHEW Thomas SMYTHE                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 2, 1986 |                                                                                                                                                             | 2b. HOUR<br>4:30 M |                                                                                                                            |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>White                                                                                                                                                                                                                                                                                                                                                                    |                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 28, 1979                                                                                                        |                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>7 YRS.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Havre de Grace, Md.                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                                                 |                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL                                                                                                                                                                                                                                             |                                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student                                                                                 |                    | 12b. KIND OF BUSINESS OR INDUSTRY<br>Elementary School                                                                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                          |  | 13b. CITY OR TOWN<br>Harford                                                                                                                                                                                                                                                                                                                                                        |                                                    | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |                    | 13d. STREET ADDRESS / ZIP CODE<br>412 Forehand Court 21014                                                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Dale (nmn) Smythe                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Randy Rae Urquhart                                                                                                                                                                                                                                                                                                                 |                                                    | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                  |                    | 16b. SOCIAL SECURITY NO.<br>216-04-2693                                                                                    |  |
| 17. INFORMANT<br>ADDRESS<br>Bel Air, Md. 21014                                                                                                                                                                                                                                                                                                                  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Werdnig-Hoffman Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hrs<br>7 yrs                                                                                             |                    |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                    |                                                                                                                                                             |                    |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br>—                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—                                                                                                                                                                                                                                                                                                                               |                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                                                                                          |                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                    |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                              |                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                    |                                                                                                                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>5-1</u> , 19 <u>86</u> , to <u>5-2</u> , 19 <u>86</u> , that (1) (we) lost saw the deceased alive on <u>5-2</u> , 19 <u>86</u> , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                    |                                                                                                                                                             |                    |                                                                                                                            |  |
| 22b. SIGNATURE<br>Elizabeth C Engle                                                                                                                                                                                                                                                                                                                             |  | DEGREE                                                                                                                                                                                                                                                                                                                                                                              |                                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                    | 22c. DATE SIGNED<br>5-2-86                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elizabeth C Engle                                                                                                                                                                                                                                                                                                      |  | 22e. ADDRESS<br>600 N. WOLFEST. BALTO. MD. 21205<br>Johns Hopkins Hosp Dept of Pediatrics                                                                                                                                                                                                                                                                                           |                                                    |                                                                                                                                                             |                    |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br>May 5, 1986                                                                                                                                                                                                                                                                                                                                                            |                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Bel Air Memorial Gardens                                                                                              |                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Bel Air Harford Md.                                                          |  |
| 24. FUNERAL DIRECTOR<br>Howard K. McConis, 111 Abingdon Rd, 21009                                                                                                                                                                                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 5 1986                                                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                             |                    |                                                                                                                            |  |
| 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                     |                                                    |                                                                                                                                                             |                    |                                                                                                                            |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate, page 4, and send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP





NOTICE

WILLIAMS

WILLIAMS

00-05282

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 1 6 8  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                          |                                                       |                                                                               |                       |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Mary Roseanna Snyder                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 28, 1986 |                                                                               | 2b. HOUR<br>8:15 P.M. |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>White                                                                                                                                                         |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 4, 1900                           |                       |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.                                                                                                                                                                                                                                                                                                                                                              |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA                                                                                                                |                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                           |                       |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                             |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                                                               |                                                       |                                                                               |                       |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Balto. General Hospital                               |                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |                       |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                                                                                                                                                                                                                                                                                                                                           |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY WINE ARUNDEL 13c. CITY OR TOWN LINTHICUM |                                                       |                                                                               |                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Harvey Stahley                                                                                                                                                                                                                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura McCurdy                                                                                                           |                                                       |                                                                               |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>180.103859                                                                                                    |                                                       | 17. INFORMANT (Son) ADDRESS<br>James R. Snyder Same as 13                     |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Inferior and Anteroseptal MI</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Inferior and Anteroseptal MI</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                                                          |                                                       |                                                                               |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                          |                                                       |                                                                               |                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                         |                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                 |                                                       |                                                                               |                       |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                           |                                                       |                                                                               |                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>PM                                                                                             |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                       |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>4/25</u> , 19 <u>86</u> , to <u>4/28</u> , 19 <u>86</u> , that (2) we lost <u>5:154/28</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above <u>and that I did not view the body after death.</u>                                                                |  |                                                                                                                                                                          |                                                       |                                                                               |                       |  |
| 22b. SIGNATURE<br><u>Basile E. Chryssos MD</u>                                                                                                                                                                                                                                                                                                                                                          |  | DEGREE                                                                                                                                                                   |                                                       | 22c. DATE SIGNED<br>4/28/86                                                   |                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BASILE E. CHRYSOS MD                                                                                                                                                                                                                                                                                                                                           |  | 22e. ADDRESS<br>SBGH<br>3001 South Hanover Street Balt. MD 21230                                                                                                         |                                                       |                                                                               |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>Apr. 29, 1986                                                                                                                                               |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process., Inc.                 |                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Balto. Prince Georges                                                                                                                                                                                                                                                                                                                         |  | 24. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home Glen Burnie, Maryland                                                                                             |                                                       |                                                                               |                       |  |
| 25. DATE REC'D. BY REGISTRY<br>MAY 1 1986                                                                                                                                                                                                                                                                                                                                                               |  | 26. REGISTRAR'S SIGNATURE                                                                                                                                                |                                                       |                                                                               |                       |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

01-02-58

20% 80% MC 100% 100%

WINTER 1958

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

86 14169

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                      |  |                                                                                                                                    |                                                                |                                                                                                                                                             |                               |                                                                                       |                                                                                                 |                                                                                                                     |                                                                        |                                                       |  |
|----------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>Sylvia</u> MIDDLE <u>C.</u> LAST <u>Snyder</u>                       |  |                                                                                                                                    | 2a. DATE OF DEATH MONTH <u>05</u> DAY <u>15</u> YEAR <u>86</u> |                                                                                                                                                             |                               | 2b. HOUR <u>1:30</u> PM                                                               |                                                                                                 |                                                                                                                     |                                                                        |                                                       |  |
| 3. SEX<br><u>F</u> EMALE                                                                                             |  | 4. RACE<br><u>W</u> HITE                                                                                                           |                                                                | 5. DATE OF BIRTH<br>MONTH <u>1</u> DAY <u>16</u> YEAR <u>11</u>                                                                                             |                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>75</u> YRS.                                     |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS <u>  </u> DAYS <u>  </u>                                                               |                                                                        | 8. IF UNDER 24 HRS.<br>HOURS <u>  </u> MIN. <u>  </u> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>PENNSYLVANIA</u>                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                         |                                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY</u> MD.                     |                                                                                                 |                                                                                                                     |                                                                        |                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Sinai Hospital</u> |                                                                |                                                                                                                                                             |                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>BOOKKEEPER</u> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>ACCOUNTING</u>                                                              |                                                                        |                                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>MD</u> |  |                                                                                                                                    | 13b. COUNTY <u>DAKOTA</u>                                      |                                                                                                                                                             | 13c. CITY OR TOWN <u>BGHT</u> |                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                     | 13e. STREET ADDRESS / ZIP CODE<br><u>4 RUSSERN CT., APT. T1 #21215</u> |                                                       |  |
| 14. FATHER'S NAME<br>FIRST <u>MORRIS</u> MIDDLE <u>  </u> LAST <u>SNYDER</u>                                         |  |                                                                                                                                    |                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>REBECCA</u> MIDDLE <u>  </u> LAST <u>SKVERSKY</u>                                                                      |                               |                                                                                       |                                                                                                 | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>NO</u> (IF YES, GIVE WAR OR DATES) <u>  </u> |                                                                        |                                                       |  |
| 16b. SOCIAL SECURITY NO.<br><u>163-03-9969</u>                                                                       |  |                                                                                                                                    |                                                                | 17. INFORMANT <u>MRS. THELMA HIMMELSTEIN</u>                                                                                                                |                               |                                                                                       |                                                                                                 | 17. ADDRESS <u>6261 ROBIN HILL RD. BALTO., MD 21207</u>                                                             |                                                                        |                                                       |  |

**18 CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CVA

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)   

DUE TO, OR AS A CONSEQUENCE OF

(c)   APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:   

## MEDICAL CERTIFICATION

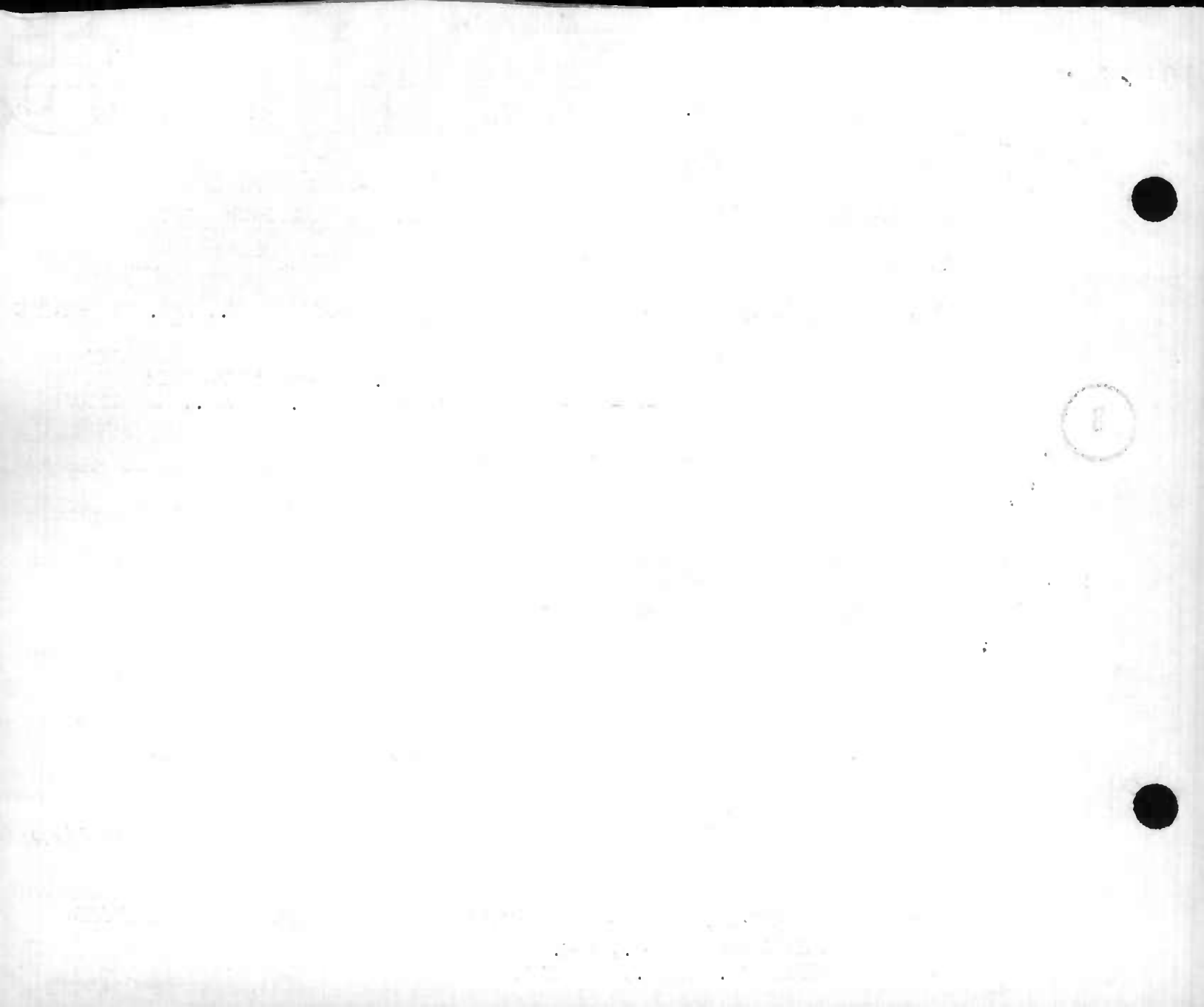
|                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                 |  |                                                                                           |  |                                                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>  </u> P.M. <u>  </u> <u>  </u> <u>19</u> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)            |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |  | 21f. LOCATION<br>STREET <u>  </u> CITY OR TOWN <u>  </u> COUNTY <u>  </u> STATE <u>  </u> |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/13</u> , 19 <u>86</u> , to <u>5/15</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>5/15</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |                                                                                                 |  |                                                                                           |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><u>Robert J. Entel, MD</u>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                 |  | DEGREE <u>  </u>                                                                          |  | 22c. DATE SIGNED<br><u>5-15-86</u>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Robert J. Entel, MD</u>                                                                                                                                                                                                                                                                                                    |  |                                                                                                 |  | 22e. ADDRESS<br><u>Sinai Hospital</u>                                                     |  |                                                                                                                               |  |

|                                                                                                             |  |                                  |  |                                                             |  |                                                                          |  |
|-------------------------------------------------------------------------------------------------------------|--|----------------------------------|--|-------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <u>BURIAL</u>                                                  |  | 23b. DATE<br><u>MAY 18, 1986</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>SHAAREI TFILOH</u> |  | 23d. LOCATION<br><u>BALTIMORE</u> COUNTY <u>  </u> STATE <u>MARYLAND</u> |  |
| 24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., INC.</u><br><u>6010 REISTERSTOWN RD. BALTO., MD 21215</u> |  |                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAY 21 1986</u>         |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Rodman</u>               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



00-06733

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14170

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                       |                         |                                                                                                                                                      |                                                   |                                                                                                                                                             |                                                   |                                                                                          |  |                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRY</b>                                                                                                      |                         |                                                                                                                                                      |                                                   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>5</b> DAY <b>9</b> YEAR <b>1986</b>                                                    |                                                   |                                                                                          |  | 2b. HOUR <b>8:50</b> AM <input checked="" type="checkbox"/> PM                  |  |
| 3. SEX<br><b>Male</b>                                                                                                                                 | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>May</b> DAY <b>18</b> YEAR <b>1935</b>                                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b> YRS. | IF UNDER 1 YR.<br>MONTHS <b>5</b> DAYS <b>9</b>                                                                                                             | IF UNDER 24 HRS.<br>HOURS <b>19</b> MIN <b>50</b> | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>5</b> DAY <b>9</b> YEAR <b>1986</b>                 |  | 2d. HOUR <b>8:50</b> AM <input checked="" type="checkbox"/> PM                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>England</b>                                                                                           |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>England</b>                                                                                                       |                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                        |  |                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                         |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. Harbor-Queen Elizabeth 2</b> |                                                   |                                                                                                                                                             |                                                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Baggage Master</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>QE2</b>                                 |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>England</b> 13b. COUNTY <b>Portsmouth</b> |                         |                                                                                                                                                      |                                                   | 13c. CITY OR TOWN<br><b>Portsmouth</b>                                                                                                                      |                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 13e. STREET ADDRESS <b>Zip- ZM811811C</b><br><b>356 Hawthorne Cresent</b> 99999 |  |
| 14. FATHER'S NAME<br>FIRST <b>Harry</b> MIDDLE <b>Alfred</b> LAST <b>Sole</b>                                                                         |                         |                                                                                                                                                      |                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Marion</b> MIDDLE <b>Frazer</b> LAST <b>Frazer</b>                                                                     |                                                   |                                                                                          |  |                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                 |                         |                                                                                                                                                      |                                                   | 16b. SOCIAL SECURITY NO.<br><b>-----</b>                                                                                                                    |                                                   | 17. INFORMANT <b>Portsmouth, England ZM811811C</b><br><b>Mary Gregory 2 Amberley Rd.</b> |  |                                                                                 |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Arteriosclerotic cardiovascular disease**

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

|                                                                                                                        |  |                                                                   |  |                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.ACTUAL SIGNATURE **Ann M. Dixon** TITLE (SPECIFY) **M.D. Assistant** MEDICAL EXAMINER DATE SIGNED **5-9-86**EXAMINER'S NAME (TYPE OR PRINT) **Ann M. Dixon, M.D.** ADDRESS **111 Penn St., Balto., MD 21201**

|                                                                                         |                             |                                                                                                           |                                                                              |
|-----------------------------------------------------------------------------------------|-----------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                           | 23b. DATE<br><b>5-30-86</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Port Chester Crematory</b>                                       | 23d. LOCATION<br>CITY OR TOWN <b>Fareham Hampshire, England</b> COUNTY STATE |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>Baltimore, Md.</b> |                             | 25a. DATE REC'D. BY REGISTRAR <b>MAY 16 1986</b> 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b> |                                                                              |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. BRETTON ST., BALTIMORE, MD. 21201. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BRETTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

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(VR AT ME (5))

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DIVISION OF VITAL RECORDS, 201 W. BRETTON ST., BALTIMORE, MD. 21201

0-00733

May 15, 1950

England

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00-07763

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14171

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                 |                                                                                              |                                                                                                 |                                                                                                                            |                                                           |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William G Spare                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5-21-86                         |                                                                                                                                                             |                                                                 | 2b. HOUR<br>8:54 PM                                                                          |                                                                                                 |                                                                                                                            |                                                           |  |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>W                                                                                                                            |                                                                        | 5. DATE OF BIRTH<br>NOV. 20 1913                                                                                                                            |                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72                                                        |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                          |                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pa.                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                     |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                    |                                                                                                 |                                                                                                                            |                                                           |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Hospital |                                                                        |                                                                                                                                                             |                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired-National Brewery |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                           |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         | 13b. COUNTY<br>Balto.                                                  |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                                  |                                                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br>502 Southern Ave. 21224 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William J. Spare                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Becker           |                                                                                                                                                             |                                                                 |                                                                                              |                                                                                                 |                                                                                                                            |                                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII        |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>Penelope Spare 502 Southern Ave. 24 |                                                                                              |                                                                                                 |                                                                                                                            |                                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hepatorenal Syndrome</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                 |                                                                                              |                                                                                                 |                                                                                                                            |                                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                 |                                                                                              |                                                                                                 |                                                                                                                            |                                                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |                                                                                                 |                                                                                                                            |                                                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                            |                                                                                                 |                                                                                                                            |                                                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/1/86</u> , 19 <u>86</u> , to <u>5/21</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/21/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                       |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                 |                                                                                              |                                                                                                 |                                                                                                                            |                                                           |  |
| 22b. SIGNATURE<br><u>Gary Applebaum</u>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                 | DEGREE<br>MD                                                                                 |                                                                                                 | 22c. DATE SIGNED<br>5/21/86                                                                                                |                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Gary Applebaum MD                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                 | 22e. ADDRESS                                                                                 |                                                                                                 |                                                                                                                            |                                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         | 23b. DATE<br>5/24/86                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge               |                                                                                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |                                                                                                                            |                                                           |  |
| 24. FUNERAL DIRECTOR<br>Connelly Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>MAY 27 1986                                                 |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>Gina Davidson-Rosen</u>                                                                   |                                                           |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

0-07583

RECEIVED

WINTER



NOTES

00-06425

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 1 7 2  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                |                                                                                                                                                             |                                                                                             |                                                                                                 |                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE H. SPENCER</b>                                                                                                                                                                                                                                                                                                       |                                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>S 10 86</b>                                       |                                                                                                 | 2b. HOUR<br><b>5 25</b><br>A M                                                                                                 |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                              | 4. RACE<br><b>White</b>                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 12, 1909</b>                                                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b><br>YRS                                         |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN.                                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                           |                                                                                                 |                                                                                                                                |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital, Balto. Md.</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>National Can Co.</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                       |                                                                                                                                                | 13b. COUNTY<br><b>-----</b>                                                                                                                                 | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1144 Gorsuch Ave. Balto. Md. 21218</b>                                                    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry --- Spencer</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose --- Ellenberg</b>                                                                                  |                                                                                             |                                                                                                 |                                                                                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                  |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br><b>212-01-2432</b>                                                                                                              |                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Mary C. Spencer, Same as above</b>                          |                                                                                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Squamous cell cancer of lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>-----</b>                                                                                |                                                                                                                                                |                                                                                                                                                             |                                                                                             |                                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Chronic obstructive pulmonary disease, atherosclerotic cardiovascular disease</b>                                                                                                                                         |                                                                                                                                                |                                                                                                                                                             |                                                                                             |                                                                                                 |                                                                                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED<br>IN IDENTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                  |                                                                                                                                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                       |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/17</b> , 19 <b>86</b> , to <b>5/10</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/10</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                                |                                                                                                                                                             |                                                                                             |                                                                                                 |                                                                                                                                |
| 22b. SIGNATURE<br><b>Michael Sykes</b>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                             | 22c. DATE SIGNED<br><b>5/10/86</b>                                                              |                                                                                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL SYLVA</b>                                                                                                                                                                                                                                                                                                      |                                                                                                                                                | 22e. ADDRESS<br><b>MERCY HOSPITAL 301 ST PAUL PL. BALTIMORE MD</b>                                                                                          |                                                                                             |                                                                                                 |                                                                                                                                |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                      |                                                                                                                                                | 23b. DATE<br><b>5/13/1986</b>                                                                                                                               |                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ivy Hill Cemetery</b>                                  |                                                                                                                                |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel, Maryland</b>                                                                                                                                                                                                                                                                                              |                                                                                                                                                | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Balto. Md. 21230<br/>McCully Funeral Home, 130 E. Fort Ave.</b>                                                  |                                                                                             |                                                                                                 |                                                                                                                                |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 13 1986</b>                                                                                                                                                                                                                                                                                                                |                                                                                                                                                | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                            |                                                                                             |                                                                                                 |                                                                                                                                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon duplicate pages 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. (If item 21 is marked or item 18 shows any injury, or other traumatic event, the body must be examined at once.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the body must be examined at once.

H



00-05438

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8614173  
REG. NO.

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                          |  |                                                                                                                                             |                                                        |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                    |                                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Pauline Marie Spissler</b>                                                                                                                     |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05 01 86</b> |                                                                                                                                                             |                                                                                                 | 2b. HOUR<br><b>8<sup>15</sup> AM</b>                                                 |                                                                    |                                                                    |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                  |  | 4. RACE<br><b>Cauc.</b>                                                                                                                     |                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 23 1914</b>                                                                                                      |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                                    |                                                                    | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  |                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.                        |                                                                    |                                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |                                                        |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                    | 12b. KIND OF BUSINESS OR INDUSTRY                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>Balto. City</b> 13c. CITY OR TOWN <b>Balto City</b> |  |                                                                                                                                             |                                                        |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                      | 13e. STREET ADDRESS / ZIP CODE<br><b>2700 Englewood Ave. 21234</b> |                                                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Roscoe Huggins</b>                                                                                                                  |  |                                                                                                                                             |                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Florence Temple</b>                |                                                                                      |                                                                    |                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>216-09-4172</b>                                                                                              |                                                        | 17. INFORMANT<br><b>James Spissler</b>                                                                                                                      |                                                                                                 | ADDRESS<br><b>Same as 13e</b>                                                        |                                                                    |                                                                    |  |

|                                                                                                                                                                                                                                                                                                       |  |                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest from Cerebral Edema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Colon Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 yrs</b> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                        |  |                                                                                                                                                                |  |                                                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>possible pneumonia</b>                                                                                                                                                                                                             |  |                                                                        |  |                                                                                                                                                                |  |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                                                                                 |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 9</b> , 19 <b>86</b> , to <b>May 1</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>May 1</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                                |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>James Barrett / Sandra Yong</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                        |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/1/86</b>                                                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James Barrett / SANDRA YONG</b>                                                                                                                                                                                                                                                                                                   |  |                                                                        |  | 22e. ADDRESS<br><b>5601 LOCK RAVEN BLVD, BALT 21239</b>                                                                                                        |  |                                                                                                                               |  |

|                                                               |  |                            |  |                                                          |  |                                                                  |  |
|---------------------------------------------------------------|--|----------------------------|--|----------------------------------------------------------|--|------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>5-5-86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b> |  |
|---------------------------------------------------------------|--|----------------------------|--|----------------------------------------------------------|--|------------------------------------------------------------------|--|

|                                                                                |  |                                                    |  |                                                  |  |
|--------------------------------------------------------------------------------|--|----------------------------------------------------|--|--------------------------------------------------|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 2 1986</b> |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |
|--------------------------------------------------------------------------------|--|----------------------------------------------------|--|--------------------------------------------------|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-07071

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon copy and send 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                        |  | 8614174<br>REG. NO.                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR<br><b>LOUISE S. STALEY</b>                                                                                                                                                                                                                                                                           |  | 2a. DATE OF DEATH MONTH <u>5</u> DAY <u>14</u> YEAR <u>86</u> 2b. HOUR <u>2:12</u> P.M.                                                        |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br><b>LOUISE SAPPINTON STALEY</b>                                                                                                                                                                                                                                                        |  | 3. SEX <b>FEMALE</b>                                                                                                                           |  |
| 4. RACE <b>CAUCASIAN</b>                                                                                                                                                                                                                                                                                                    |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6-14-1894</b>                                                                                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>                                                                                                                                                                                                                                                                                   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO. MD.</b>                                                                                     |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>                                                                                 |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UPLANDS HOME FOR CHURCH WOMEN</b> |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>                                                                                                                                                                                                                                                |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>HOMEMAKER</b>                                                                                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b>                                                                                                                                                                                                       |  | 13b. COUNTY <b>--</b>                                                                                                                          |  |
| 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                                                                                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                   |  |
| 13e. STREET ADDRESS <b>4501 Old Frederick Road 21229</b>                                                                                                                                                                                                                                                                    |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>PURNELL FLETCHER SAPPINGTON</b>                                                                      |  |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>BESSIE C. RINGGOLD</b>                                                                                                                                                                                                                                                     |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>                                                                    |  |
| 16b. SOCIAL SECURITY NO. <b>219-01-2466</b>                                                                                                                                                                                                                                                                                 |  | 17. INFORMANT ADDRESS<br><b>Louise Leake 287 A Deer Trail Ct. Barrington, Ill. 60010</b>                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PARKINSON'S DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>X 3 years</b>                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ASCUS CARCINOMA of COLON</b>                                                                                                                                                         |  |                                                                                                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                 |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                                                                                                                                                                              |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                         |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                |  |
| 22b. SIGNATURE <b>Alva S. Baker MD</b>                                                                                                                                                                                                                                                                                      |  | 22c. DATE SIGNED <b>5-14-86</b>                                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alva S. Baker</b>                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS <b>330-140 Village Road Westminster, MD 21157-6116</b>                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>                                                                                                                                                                                                                                                                  |  | 23b. DATE <b>5/15/86</b>                                                                                                                       |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>                                                                                                                                                                                                                                                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Catonsville Maryland</b>                                                                         |  |
| 24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b>                                                                                                                                                                                                                                             |  | 25. DATE OF DEATH REGISTRATION <b>MAY 20 1986</b>                                                                                              |  |
| 26. ADDRESS <b>1630 Edmondson Avenue, Catonsville, MD. 21228</b>                                                                                                                                                                                                                                                            |  | 27. REGISTRAR'S SIGNATURE <b>June Davidson-Hamaker</b>                                                                                         |  |



00-00000



100% COTTON

MAY 30 1966

00-07663

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 1 7 5  
REG. NO.

|                                                                               |  |                                                                                                                                         |                                                     |                                                                                                        |                      |  |
|-------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>HELEN A. STACHURA |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 24, 1986 |                                                                                                        | 2b. HOUR<br>3:15 A M |  |
| 3 SEX<br>FEMALE                                                               |  | 4 RACE<br>CAUC.                                                                                                                         |                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 7 11                                                           |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                     |                                                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.                                                              |                      |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                              |                      |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—                                                                                                  |                                                     | 13a. STREET ADDRESS / ZIP CODE<br>707 S. GLOVER ST. 21224                                              |                      |  |
| 13a. STATE<br>MARYLAND                                                        |  | 13b. COUNTY<br>—                                                                                                                        |                                                     | 13c. CITY OR TOWN<br>BALTIMORE                                                                         |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN CHACHULSKI                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>EVA KORDONSKI                                                                          |                                                     | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |                      |  |
| 16b. SOCIAL SECURITY NO.<br>—                                                 |  | 17 INFORMANT<br>JOHN STACHURA                                                                                                           |                                                     | 18. ADDRESS<br>14652 WEXHALL TERR.                                                                     |                      |  |

|                                                                                                                                                |  |                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Failure |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>43 hours |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Myocardial infarction with mitral regurgitation                                                          |  | 43 hours                                                    |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) Atherosclerotic Coronary Artery Disease                                                                  |  | 4 months                                                    |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|                                                                                                                                                                                                                                                                                                               |  |                                                                                                    |  |                                                                                                                                                      |  |                                                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION<br>5/22/86                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Coronary Artery Disease / Mitral Insufficiency |  | 20a. AUTOPSY?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                 |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                         |  | 21c. HOW INJURY OCCURRED<br>ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2                                                                      |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from 5/22 19 86 to 5/24 19 86, that (I) (we) last saw the deceased alive on 5/24 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                    |  |                                                                                                                                                      |  |                                                                                                                               |  |
| 22b. SIGNATURE<br>Raymond D. Mossie, M.D.                                                                                                                                                                                                                                                                     |  |                                                                                                    |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>5/24/86                                                                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAYMOND D. MOSSIE                                                                                                                                                                                                                                                    |  |                                                                                                    |  | 22e. ADDRESS<br>601 N. BROADWAY BALTIMORE, MD 21205                                                                                                  |  |                                                                                                                               |  |

|                                                        |  |                         |  |                                                           |  |                                                            |  |
|--------------------------------------------------------|--|-------------------------|--|-----------------------------------------------------------|--|------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL |  | 23b. DATE<br>5/27/86    |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. STANISLAUS CEM. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>KACOROWSKI             |  | ADDRESS<br>FUNERAL HOME |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 27 1986              |  | 25b. REGISTRAR'S SIGNATURE<br>June Davidson-Henderson      |  |



00-06524

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO.

1 4 1 7 6

|                                                                                                                                    |         |                                                                                                                                                                                                      |  |                                                                                       |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
|------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                |         | FIRST                                                                                                                                                                                                |  | MIDDLE                                                                                |  | LAST                                                                |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED    |  | MONTH                    |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| STERLING Thomas                                                                                                                    |         | STANFIELD                                                                                                                                                                                            |  | Jr.                                                                                   |  |                                                                     |  | <input checked="" type="checkbox"/>          |  | 5                        |  | 7     |  | 1986 |  | 2:23 PM  |  |
| 3. SEX                                                                                                                             | 4. RACE | 5. DATE OF BIRTH                                                                                                                                                                                     |  | 6. AGE (IN YEARS)                                                                     |  | IF UNDER 1 YR.                                                      |  | IF UNDER 24 HRS.                             |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| Male                                                                                                                               | Black   | 05-30-66                                                                                                                                                                                             |  | 19 YRS.                                                                               |  |                                                                     |  |                                              |  | 5                        |  | 7     |  | 1986 |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                          |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |                          |  |       |  |      |  |          |  |
| Balto., Md.                                                                                                                        |         | USA                                                                                                                                                                                                  |  |                                                                                       |  |                                                                     |  | Baltimore City                               |  |                          |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                          |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                                                           |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                              |  |                          |  |       |  |      |  |          |  |
| Baltimore                                                                                                                          |         | University Hospital                                                                                                                                                                                  |  |                                                                                       |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
| 13a. STATE                                                                                                                         |         | 13b. COUNTY                                                                                                                                                                                          |  | 13c. CITY OR TOWN                                                                     |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                          |  |                          |  |       |  |      |  |          |  |
| Maryland                                                                                                                           |         | Baltimore                                                                                                                                                                                            |  | Baltimore                                                                             |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 19 South Arlington Avenue                    |  |                          |  |       |  |      |  |          |  |
| 14. FATHER'S NAME                                                                                                                  |         | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                             |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                 |  | 16b. SOCIAL SECURITY NO.                                            |  | 17. INFORMANT                                |  |                          |  |       |  |      |  |          |  |
| Sterling Thomas Stanfield Sr.                                                                                                      |         | Annie Ruth Stanfield                                                                                                                                                                                 |  | No                                                                                    |  |                                                                     |  | Annie Stanfield                              |  | 19 S. Arlington Ave.     |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                          |         | PART I DEATH WAS CAUSED BY:                                                                                                                                                                          |  | IMMEDIATE CAUSE (a)                                                                   |  | GUESS                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                          |  |       |  |      |  |          |  |
|                                                                                                                                    |         |                                                                                                                                                                                                      |  | Gunshot wound of chest (unspecified weapon)                                           |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
|                                                                                                                                    |         |                                                                                                                                                                                                      |  | DUE TO, OR AS A CONSEQUENCE OF                                                        |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
|                                                                                                                                    |         |                                                                                                                                                                                                      |  | (b)                                                                                   |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
|                                                                                                                                    |         |                                                                                                                                                                                                      |  | DUE TO, OR AS A CONSEQUENCE OF                                                        |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
|                                                                                                                                    |         |                                                                                                                                                                                                      |  | (c)                                                                                   |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |         |                                                                                                                                                                                                      |  |                                                                                       |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION                                                                                                             |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                                                    |  | 20. AUTOPSY?                                                                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |                          |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH     |         | 21b. TIME OF INJURY                                                                                                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
|                                                                                                                                    |         | 12:47 PM 5-7-1986                                                                                                                                                                                    |  | Subject shot.                                                                         |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK                  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                                                          |  | 21f. LOCATION                                                                         |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
|                                                                                                                                    |         | street                                                                                                                                                                                               |  | 1100 blk. W. Lexington St., Balto. City                                               |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:                                     |         | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion                                                                   |  |                                                                                       |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
|                                                                                                                                    |         | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                       |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
| ACTUAL SIGNATURE                                                                                                                   |         | TITLE (SPECIFY)                                                                                                                                                                                      |  | DATE SIGNED                                                                           |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
| Dennis F. Smyth, M.D.                                                                                                              |         | Assistant                                                                                                                                                                                            |  | 5-8-86                                                                                |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                    |         | ADDRESS                                                                                                                                                                                              |  |                                                                                       |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
|                                                                                                                                    |         | 111 Penn St., Balto., MD 21201                                                                                                                                                                       |  |                                                                                       |  |                                                                     |  |                                              |  |                          |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                          |         | 23b. DATE                                                                                                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY                                                    |  | 23d. LOCATION                                                       |  |                                              |  |                          |  |       |  |      |  |          |  |
| Burial                                                                                                                             |         | 05-12-86                                                                                                                                                                                             |  | Arbutus Memorial Park                                                                 |  | Baltimore, Maryland                                                 |  |                                              |  |                          |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR                                                                                                               |         | NAME                                                                                                                                                                                                 |  | ADDRESS                                                                               |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                   |  |                          |  |       |  |      |  |          |  |
| Brown/Thompson F.H.                                                                                                                |         | 1913 W. Baltimore Street                                                                                                                                                                             |  |                                                                                       |  | MAY 14 1986                                                         |  |                                              |  |                          |  |       |  |      |  |          |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSFER, PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

 DHMH - 17  
 (VR A15 ME (5))  
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ADVISORY

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. 4177

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                  |                  |                                                                                                                                   |  |                                                                 |  |                                                                                                                                                             |                  |                                                                                                |  |                                                                                     |  |                                              |               |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|----------------------------------------------|---------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |  |                  | FIRST<br>Herbert |                                                                                                                                   |  | MIDDLE<br>E.                                                    |  |                                                                                                                                                             | LAST<br>STANFORD |                                                                                                |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>5-5-86 19                                   |  |                                              | 2b. HOUR<br>M |  |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>NEGRO |                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 17 49                                                                                     |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>37 YRS.                   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                 |                  | 7c. DATE PRONOUNCED DEAD<br>5-5-86 19                                                          |  | 2d. HOUR<br>7:35a                                                                   |  |                                              |               |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                                                                                                                                          |  |                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                            |  |                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  |                                                                                                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City                              |  |                                              |               |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>503 E. 21st. Street |  |                                                                 |  |                                                                                                                                                             |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bayman Unemployment Insurance |  |                                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY            |               |  |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                  |                  | 13b. COUNTY                                                                                                                       |  | 13c. CITY OR TOWN<br>BALTO.                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                  | 13e. STREET ADDRESS<br>503 E. 21st ST 21218                                                    |  |                                                                                     |  |                                              |               |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILMER H. STANFORD                                                                                                                                                                                                                                                                                                                                                                             |  |                  |                  |                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CARRIE HAWKINS |  |                                                                                                                                                             |                  |                                                                                                |  |                                                                                     |  |                                              |               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                               |  |                  |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220 53 2508                                                            |  | 17. INFORMANT<br>ADDRESS<br>TONI STANFORD 3905 Frankford Ave    |  |                                                                                                                                                             |                  |                                                                                                |  |                                                                                     |  |                                              |               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Combined drug intoxication<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                            |  |                  |                  |                                                                                                                                   |  |                                                                 |  |                                                                                                                                                             |                  |                                                                                                |  |                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |               |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                       |  |                  |                  |                                                                                                                                   |  |                                                                 |  |                                                                                                                                                             |                  |                                                                                                |  |                                                                                     |  |                                              |               |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                 |  |                                                                 |  |                                                                                                                                                             |                  |                                                                                                |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                              |               |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                           |  |                  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>100 P.M. 5/5 19 86                                                             |  |                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>ingestion drugs                                                            |                  |                                                                                                |  |                                                                                     |  |                                              |               |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                        |  |                  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home                                                               |  |                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>503 E. 21st Street, Baltimore City                                                                     |                  |                                                                                                |  |                                                                                     |  |                                              |               |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                  |                                                                                                                                   |  |                                                                 |  |                                                                                                                                                             |                  |                                                                                                |  |                                                                                     |  |                                              |               |  |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell                                                                                                                                                                                                                                                                                                                                                                                                  |  |                  |                  | TITLE (SPECIFY)<br>M.D. Assistant                                                                                                 |  |                                                                 |  | MEDICAL EXAMINER                                                                                                                                            |                  |                                                                                                |  | DATE SIGNED<br>5-5-86                                                               |  |                                              |               |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                          |  |                  |                  | ADDRESS<br>111 Penn Street                                                                                                        |  |                                                                 |  |                                                                                                                                                             |                  |                                                                                                |  |                                                                                     |  |                                              |               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |                  | 23b. DATE<br>5/10/86                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTO. CO.                |  |                                                                                                                                                             |                  | 23d. LOCATION<br>CITY OR TOWN STATE<br>BALTO. MD                                               |  |                                                                                     |  |                                              |               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>LOCK'S FUNERAL HOME                                                                                                                                                                                                                                                                                                                                                                                      |  |                  |                  | ADDRESS<br>1304 N. Central Ave                                                                                                    |  |                                                                 |  | DATE REC'D. BY REGISTRAR<br>MAY 7 1986                                                                                                                      |                  |                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>Margarita A. Korell                                   |  |                                              |               |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4  
25MDHMH - 17  
(VR A15 ME (5))

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1/1/65



00-08347

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 1 7 8  
REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                  |                                                     |                                                                                                                                                             |                             |                                                                                      |                                                                                                 |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph H. Staton                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 30 86      |                                                                                                                                                             |                             | 2b. HOUR<br>M<br>M                                                                   |                                                                                                 |                                                                                                                            |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>Black                                                                                                                 |                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 6 06                                                                                                                |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.                                           |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A                                                                                            |                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.                           |                                                                                                 |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2110 Clifton Avenue |                                                     |                                                                                                                                                             |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired          |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                  | 13b. COUNTY                                         |                                                                                                                                                             | 13c. CITY OR TOWN<br>Balto. |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>NA                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>NA |                                                                                                                                                             |                             | 13e. STREET ADDRESS / ZIP CODE<br>2110 Clifton Avenue 21217                          |                                                                                                 |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-01-0889                                                           |                                                     | 17. INFORMANT<br>Warren Bumgardner                                                                                                                          |                             |                                                                                      | ADDRESS<br>2110 Clifton Ave.                                                                    |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                  |                                                     |                                                                                                                                                             |                             |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 yrs.                                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerotic Heart Disease</u>                                                                                                                                                                                       |  |                                                                                                                                  |                                                     |                                                                                                                                                             |                             |                                                                                      |                                                                                                 |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |                                                     |                                                                                                                                                             |                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                       |                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                             |                                                                                      |                                                                                                 |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                           |                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                             |                                                                                      |                                                                                                 |                                                                                                                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>4/10</u> 19 <u>80</u> to <u>5/30</u> 19 <u>86</u> , that (I) (we) saw the deceased alive on <u>4/10</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                 |  |                                                                                                                                  |                                                     |                                                                                                                                                             |                             |                                                                                      |                                                                                                 |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                  |                                                     | DEGREE<br>MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |                             |                                                                                      |                                                                                                 | 22c. DATE SIGNED<br>5/30/86                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MORTON M. MONER MD                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                  |                                                     | 22e. ADDRESS<br>200 W. COLUSKING LA.                                                                                                                        |                             |                                                                                      |                                                                                                 |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br>6/3/86                                                                                                              |                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park                                                                                                    |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randallstown MD                        |                                                                                                 |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March FH West                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  |                                                     | ADDRESS<br>4300 Wabash Ave                                                                                                                                  |                             | 25a. DATE REC'D. BY REGISTRAR<br>JUN 3 1986                                          |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                           |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-000000



00-07799

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the "page 1" and "page 2" and mail within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

|                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                           |  |                                                                                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                     |  |                                                                                                                                           |  | 8614179<br>REG. NO.                                                                                                                                         |  |
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                   |  |                                                                                                                                           |  |                                                                                                                                                             |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>George I STEBBINS                                                                                                                                                                                                                                  |  |                                                                                                                                           |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 27 86                                                                                                                 |  |
| 3 SEX<br>male                                                                                                                                                                                                                                                                                            |  | 4 RACE<br>Caucasian                                                                                                                       |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 - 14 - 43                                                                                                             |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br>42 YRS.                                                                                                                                                                                                                                                                |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                             |  | 2b. HOUR<br>7:33 A.M.                                                                                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                                                                                                                                                                                               |  |                                                                                                                                           |  |                                                                                                                                                             |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE, MD                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LAWYER                                                                                     |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>SERVICE                                                                                                                                                                                                                                                             |  |                                                                                                                                           |  |                                                                                                                                                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY<br>MARYLAND TALBOT                                                                                                                                                                   |  |                                                                                                                                           |  | 13c. CITY OR TOWN<br>BOZMAN                                                                                                                                 |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                          |  | 13e. STREET ADDRESS / ZIP CODE<br>STEERING HOUSE 21612                                                                                    |  |                                                                                                                                                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>FREDERICK STEBBINS                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ELIZABETH CRAFT                                                                             |  |                                                                                                                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>181-34-4661                                                                                                   |  | 17. INFORMANT ADDRESS<br>Mrs. Elizabeth Alverson 509 Liberty St. Warren, Pa.                                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) LIVER FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (b) BLEEDING GASTRIC VARIX<br>DUE TO, OR AS A CONSEQUENCE OF (c) CIRRHOSIS of Liver                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 days<br>10 days<br>1 yr                                                                |  |                                                                                                                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                      |  |                                                                                                                                           |  |                                                                                                                                                             |  |
| 19a. DATE OF OPERATION<br>5-17-86                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>portal hypertension & bleeding                                                        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                                                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                       |  | 21f. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-17-86, 19, to 5-27-86, 19, that (I) (we) last saw the deceased alive on 5-27-86, 19, and that in my (our) opinion death occurred on the date and hour and I am the causes stated above, (I) (we) did not view the body after death. |  |                                                                                                                                           |  |                                                                                                                                                             |  |
| 22b. SIGNATURE<br>R. Zickler                                                                                                                                                                                                                                                                             |  | DEGREE<br>MD                                                                                                                              |  | 22c. DATE SIGNED<br>5-27-86                                                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RODERICK P. ZICKLER MD                                                                                                                                                                                                                                          |  | 22e. ADDRESS<br>22 S. Greene St. Balt MD 21201                                                                                            |  |                                                                                                                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal                                                                                                                                                                                                                                                     |  | 23b. DATE<br>5-27-86                                                                                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  |
| 23d. LOCATION CITY OR TOWN<br>BALTO.                                                                                                                                                                                                                                                                     |  | 23e. COUNTY<br>BALTO.                                                                                                                     |  | 23f. STATE<br>MD.                                                                                                                                           |  |
| 24. FUNERAL DIRECTOR NAME<br>Anatomy Board                                                                                                                                                                                                                                                               |  | ADDRESS<br>Balto., Md.                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 28 1986                                                                                                                |  |
|                                                                                                                                                                                                                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br>Jana Davidson-Randall                                                                                       |  |                                                                                                                                                             |  |



00-06830

Item 18athru 22aFilmG616 5/23/ STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 6

REG. NO. 14180

|                                                                                                                                                                                                                                                                                                                                                                                                                                       |        |                                                         |         |                                                                     |            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|---------------------------------------------------------|---------|---------------------------------------------------------------------|------------|
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                    |        | 2a DATE KNOWN OF DEATH                                  |         | 2b HOUR                                                             |            |
| DAVID                                                                                                                                                                                                                                                                                                                                                                                                                                 |        | Michael                                                 |         | STEINBERG                                                           |            |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4 RACE | 5 DATE OF BIRTH                                         | 6 AGE   | 7a BIRTHPLACE                                                       | 7b CITIZEN |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                  | White  | Nov. 19, 1954                                           | 31 YRS. | England                                                             | U.S.A.     |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              |        | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |         | 12a USUAL OCCUPATION                                                |            |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                             |        | St. Agnes Hospital                                      |         | Student                                                             |            |
| 13a STATE                                                                                                                                                                                                                                                                                                                                                                                                                             |        | 13b COUNTY                                              |         | 13c CITY OR TOWN                                                    |            |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                              |        | P.G.                                                    |         | Hyattsville                                                         |            |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                      |        | 15 MOTHER'S MAIDEN NAME                                 |         | 16a DECEASED EVER IN U.S. ARMED FORCES?                             |            |
| Samuel M.T. Steinberg                                                                                                                                                                                                                                                                                                                                                                                                                 |        | Lillian Evans                                           |         | No                                                                  |            |
| 16b SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                               |        | 17 INFORMANT                                            |         | 18 CAUSE OF DEATH                                                   |            |
| 212-66-9796                                                                                                                                                                                                                                                                                                                                                                                                                           |        | Mr. Samuel Steinberg                                    |         | Schizophrenia with seizure activity                                 |            |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |        | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED?        |         | 20 AUTOPSY?                                                         |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                       |        |                                                         |         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |            |
| 21a EXTERNAL CAUSE WAS                                                                                                                                                                                                                                                                                                                                                                                                                |        | 21b TIME OF INJURY                                      |         | 21c HOW INJURY OCCURRED                                             |            |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                           |        | HOUR A.M. MONTH DAY YEAR                                |         | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2                  |            |
| 21d INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                   |        | 21e PLACE OF INJURY                                     |         | 21f LOCATION                                                        |            |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                   |        | STREET, FACTORY, FARM, ETC.)                            |         | STREET CITY OR TOWN COUNTY STATE                                    |            |
| 22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |        |                                                         |         |                                                                     |            |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                      |        | TITLE (SPECIFY)                                         |         | DATE SIGNED                                                         |            |
| Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                    |        | M.D. Assistant                                          |         | 5-14-86                                                             |            |
| EXAMINER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                       |        | ADDRESS                                                 |         | 23a BURIAL, CREMATION, REMOVAL                                      |            |
| (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                       |        | 111 Penn St., Balto., MD 21201                          |         | (SPECIFY)                                                           |            |
| 23b DATE                                                                                                                                                                                                                                                                                                                                                                                                                              |        | 23c NAME OF CEMETERY OR CREMATORY                       |         | 23d LOCATION                                                        |            |
| May 16, 1986                                                                                                                                                                                                                                                                                                                                                                                                                          |        | George Washington Cem.                                  |         | Adelphi P.G. Maryland                                               |            |
| 24 FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                   |        | 25a DATE REC'D. BY REGISTRAR                            |         | 25b REGISTRAR'S SIGNATURE                                           |            |
| F. Gasch's Sons F.H. P.A. Hyattsville, Maryland                                                                                                                                                                                                                                                                                                                                                                                       |        | MAY 16 1986                                             |         | John Davidson                                                       |            |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE MARGINS OF THIS FORM. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AND PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER - CREMATION - DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP 141  
DHMH - 17  
(VR A15 ME (5))

Michael

Male White Nov. 1, 1972 21

England I.A.A.

School Student

11-6 Nicholson Street 20782 X Gymnastic

London England 21 years 2000 cm 11.11.72

Mr. Trevor Steigberg 212-06-8708



During May 16, 1988 Agents Washington Co., Virginia

2. Joseph Don T.H. 1. Westville, Maryland May 16, 1988

0-07241

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8614181  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         |                                                                        |                                                                                                                                                  |                                                               |                                                                                    |                                                                                                 |                                                                                                                            |                                                             |                                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EDWARD PATRICK STEINMETZ                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 19 86                         |                                                                                                                                                  | 2b. HOUR<br>10 A.M.                                           |                                                                                    |                                                                                                 |                                                                                                                            |                                                             |                                                              |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br>WHITE                                                                                                                        |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 24 11                                                                                                    |                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.                                         |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |                                                             | IF UNDER 24 HRS.<br>HOURS MIN.                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD.                              |                                                                                                 |                                                                                                                            |                                                             |                                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Deaton Hosp Medical Center |                                                                        |                                                                                                                                                  |                                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Grain Elevator |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>B&O Railroad                                                                          |                                                             |                                                              |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         | 13b. COUNTY                                                            |                                                                                                                                                  | 13c. CITY OR TOWN<br>Baltimore                                |                                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br>1714 Wilkens Avenue 21223 |                                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lydia Arnold          |                                                                                                                                                  |                                                               |                                                                                    |                                                                                                 |                                                                                                                            |                                                             |                                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                               |  |                                                                                                                                         | 16b. SOCIAL SECURITY NO<br>218-05-6510                                 |                                                                                                                                                  | 17. INFORMANT ADDRESS<br>Frank Garbo 1724 Ramsey Street 21223 |                                                                                    |                                                                                                 |                                                                                                                            |                                                             |                                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>AS CVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>AS CVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                                                                         |                                                                        |                                                                                                                                                  |                                                               |                                                                                    |                                                                                                 |                                                                                                                            |                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>780<br>years |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>CVA &amp; heart paresis, dementia</u>                                                                                                                                                                                     |  |                                                                                                                                         |                                                                        |                                                                                                                                                  |                                                               |                                                                                    |                                                                                                 |                                                                                                                            |                                                             |                                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                  |                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                             |                                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              |  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                  |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)      |                                                                                                 |                                                                                                                            |                                                             |                                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                         |  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                  |                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |                                                                                                 |                                                                                                                            |                                                             |                                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/19/86</u> to <u>5/19/86</u> , that (we) last saw the deceased alive on <u>5/19/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.                                                 |  |                                                                                                                                         |                                                                        |                                                                                                                                                  |                                                               |                                                                                    |                                                                                                 |                                                                                                                            |                                                             |                                                              |  |
| 22b. SIGNATURE<br><u>Dr. Gladue, MD</u> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                                         |  |                                                                                                                                         |                                                                        |                                                                                                                                                  |                                                               | 22c. DATE SIGNED<br>5/19/86                                                        |                                                                                                 |                                                                                                                            |                                                             |                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Gladue                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         |                                                                        |                                                                                                                                                  |                                                               | 22e. ADDRESS<br>Deaton Medical Center                                              |                                                                                                 |                                                                                                                            |                                                             |                                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         | 23b. DATE<br>5/22/86                                                   |                                                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery  |                                                                                    |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                                           |                                                             |                                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229                                                                                                                                                                                                                                                                           |  |                                                                                                                                         |                                                                        |                                                                                                                                                  |                                                               | 25a. DATE REC'D. BY REGISTRAR<br>MAY 21 1986                                       |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>Jane Davidson-Pandell</u>                                                                 |                                                             |                                                              |  |

MEDICAL CERTIFICATION

9  
9

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP





00-07804

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

14182

|                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                                                         |                                                                                                                                                             |                              |                                                                                                                            |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Steward W Steptoe</u>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>5-23-1986</u> |                                                                                                                                                             | 2b. HOUR<br><u>5:30</u> A.M. |                                                                                                                            |                                              |
| 3. SEX<br><u>MALE</u>                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><u>BLACK</u>                                                                                                               |                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>1 25 1914</u>                                                                                                      |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>72</u> YRS                                                                           |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>VIRGINIA</u>                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                         |                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY</u> MD.                                                          |                                              |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>LUTHERAN HOSPITAL</u> |                                                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>LABORER</u>                                                                          |                              | 12b. INDUSTRY<br><u>TURNER CONSTR. CO.</u>                                                                                 |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><u>MARYLAND</u>                                                                                                                                                                                                                                           |  |                                                                                                                                       |                                                         | 13b. COUNTY<br><u>BALTIMORE</u>                                                                                                                             |                              | 13c. CITY OR TOWN<br><u>BALTIMORE</u>                                                                                      |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>WILLIAM STEPTOE</u>                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>UNKNOWN UNKNOWN</u>                                                               |                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                              | 13e. STREET ADDRESS / ZIP CODE<br><u>1510 W. MOSHER STREET<br/>BALTIMORE, MD. 21217</u>                                    |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO.</u>                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br><u>226-14-8043</u>                                                                                        |                                                         | 17. INFORMANT<br><u>4112 FAIRFAX ROAD<br/>MARY LORRAINE JOHNSON BALTO, MD. 21216</u>                                                                        |                              |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Lung Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.       |  |                                                                                                                                       |                                                         |                                                                                                                                                             |                              |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                |  |                                                                                                                                       |                                                         |                                                                                                                                                             |                              |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |                                                         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                              |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                              |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> , 19 <u>86</u> , to <u>5/23</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5/23</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                       |                                                         |                                                                                                                                                             |                              |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><u>R - Lirgis</u>                                                                                                                                                                                                                                                                                                                                |  | DEGREE                                                                                                                                |                                                         | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                              | 22c. DATE SIGNED<br><u>5/23/86</u>                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Rafat Y. Girgis</u>                                                                                                                                                                                                                                                                                                    |  | 22e. ADDRESS<br><u>Lutheran Hospital - Baltimore</u>                                                                                  |                                                         |                                                                                                                                                             |                              |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><u>5/27/86</u>                                                                                                           |                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><u>KING MEMORIAL PARK</u>                                                                                             |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BALTIMORE, MARYLAND</u>                                                   |                                              |
| 24. FUNERAL HOME, INC.<br>NAME ADDRESS<br><u>2501 GWYNNS FALLS PKWY, BALTO. MD. 21216</u>                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |                                                         | 25a. DATE REC'D. BY REGISTRAR<br><u>MAY 28 1986</u>                                                                                                         |                              | 25b. REGISTRAR'S SIGNATURE<br><u>Juha Davidson</u>                                                                         |                                              |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cause of death. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP \_\_\_\_\_

0-1800

WIKI TEL

WIKI TEL

WIKI TEL

WIKI TEL

WIKI TEL

00-07960

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover (page 3) and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                                 |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |  | 8 6 1 4 1 8 3<br>REG. NO.                                                                                                                                   |  |                                                                                    |  |                                                                                                 |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Richard Sterrett</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                               |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 26, 1986</b>                                                                                                  |  |                                                                                    |  | 2b. HOUR<br><b>7:19A</b><br>M                                                                   |  |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>Black</b>                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 9, 1911</b>                                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b><br>YRS.                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |  |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b><br>MD.               |  |                                                                                                 |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>0</b>                                                   |  |                                                                                                                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                               |  | 13b. COUNTY<br><b>None</b>                                                                                                                                  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1728 Darley Ave. 21213</b>                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Sterrett</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Isabel Wright</b>                                                                                       |  |                                                                                    |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>None</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>217-16-8695</b>                                                                                                              |  | 17. INFORMANT<br>ADDRESS<br><b>Marion Christian, 1728 Darley Ave.</b>              |  |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                              |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                                 |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><b>Pneumothorax, Insulin dependent diabetes Mellitus, Anemia</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |  |                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  |                                                                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                            |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 21</b> , 19 <b>86</b> , to <b>May 26</b> , 19 <b>86</b> , that (I) <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>May 26</b> , 19 <b>86</b> , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Jorge E. Ferrer M.D.</b><br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |  |                                                                                                                                                             |  |                                                                                    |  | 22c. DATE SIGNED<br><b>5/26/86</b>                                                              |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jorge E. Ferrer, M. D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               |  |                                                                                                                                                             |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                               |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                               |  | 23b. DATE<br><b>5/31/86</b>                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Zion Cemetery</b>                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Law Funeral Home 4611 Park Heights Ave. 21215</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               |  |                                                                                                                                                             |  | 25. DATE RECEIVED BY REGISTRAR'S SIGNATURE<br><b>MAY 29 1986</b>                   |  |                                                                                                 |  |                                                                                                                            |  |



Postmarked 10/10/10

5-5 8/5/86  
00-07475

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                         |  |                                                                                                                                   |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                       |  | 86                                                                                                                                |  | 14184                                                                                                                                                   |  | REG. NO.                                                                                                                                   |  |                                                         |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Leon A Stevens</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>MAY 21, 86</b>                                                                                                    |  | 2b HOUR<br><b>1008 M</b>                                                                                                                   |  |                                                         |  |
| 3 SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                            |  | 4 RACE<br><b>B</b>                                                                                                                |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>12 14 38</b>                                                                                                       |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>47</b> YRS                                                                                            |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                        |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>                                                                            |  |                                                         |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                 |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Univ. MD Hospital</b> |  |                                                                                                                                                         |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Disabled</b>                                                            |  | 12b KIND OF BUSINESS OR INDUSTRY                        |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY<br><b>MD BALT. CITY</b>                                                                                                                                                                                                                     |  | 13c CITY OR TOWN<br><b>BALT</b>                                                                                                   |  | 14 INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                              |  | 13e STREET ADDRESS / ZIP CODE<br><b>1548 E. Coldspring LA 21218</b>                                                                        |  |                                                         |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>FRANCIS JOWN GERALD</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>LEOLA NOUN PATTERSON</b>                                                                                |  |                                                                                                                                            |  |                                                         |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES</b>                                                                                                                                                                                                                                                   |  | 16b SOCIAL SECURITY NO.<br><b>216-34-5985</b>                                                                                     |  | 17 INFORMANT ADDRESS<br><b>NINA MCKNIGHT 1548 E. COLDSRING LANE</b>                                                                                     |  |                                                                                                                                            |  |                                                         |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOMYOPATHY</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>UNKNOWN</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)               |  |                                                                                                                                   |  |                                                                                                                                                         |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Arrhythmias Rheumatic Heart Disease</b>                                                                                                                                                                            |  |                                                                                                                                   |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                         |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                        |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |                                                         |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                            |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                     |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)                                                                            |  |                                                                                                                                            |  |                                                         |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                        |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                            |  |                                                         |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>MAY 12</b> 19 <b>86</b> , to <b>May 21</b> 19 <b>86</b> , that (I) (we) saw the deceased alive on <b>May 21</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                   |  |                                                                                                                                                         |  |                                                                                                                                            |  |                                                         |  |
| 22b SIGNATURE<br><b>Carl Thomas</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   |  | DEGREE<br><b>MD</b>                                                                                                                                     |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><b>21 May 86</b>                     |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARL THOMAS MD</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |  | 22e ADDRESS<br><b>22 S. Greene St Baltimore MD</b>                                                                                                      |  |                                                                                                                                            |  |                                                         |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                    |  | 23b DATE<br><b>5-27-86</b>                                                                                                        |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>GARRISON FOREST</b>                                                                                             |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br><b>OWING MILLS MARYLAND</b>                                                                      |  |                                                         |  |
| 24 FUNERAL DIRECTOR NAME<br><b>WM.C.MARCH F/H INC.</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   |  | ADDRESS<br><b>1101 E. NORTH AVENUE</b>                                                                                                                  |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAY 23 1986</b>                                                                                         |  | 25b REGISTRAR'S SIGNATURE<br><b>Jane Vanden Honderd</b> |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and retain them until 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4:55 PM



0-09339

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 1 8 5  
REG. NO.

|                                                                                       |                                                                                                                                                 |                                                                                                                                                             |                                                                  |                                                                                      |                                                        |
|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Baby Boy Stevenson</u> |                                                                                                                                                 |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>5 31 86</u>            |                                                                                      | 2b. HOUR<br><u>5:07 PM</u>                             |
| 1. SEX<br><u>M</u>                                                                    | 4. RACE<br><u>W</u>                                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>5 30 86</u>                                                                                                        |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>0</u> YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br><u>1</u>             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Md.</u>                               | 7b. CITIZEN OF WHAT COUNTRY?<br><u>US</u>                                                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore</u> MD.                         |                                                        |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Univ. of Md. Medical System</u> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY                                                    |                                                        |
| 13a. STATE<br><u>Md.</u>                                                              |                                                                                                                                                 | 13b. COUNTY<br><u>Somerset</u>                                                                                                                              | 13c. CITY OR TOWN<br><u>Eden</u>                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><u>UNKNOWN 21822</u> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Willard L Rarr III</u>                   |                                                                                                                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Lisa K Stevenson</u>                                                                                    |                                                                  |                                                                                      |                                                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>No</u>     | 16b. SOCIAL SECURITY NO.<br><u>None</u>                                                                                                         |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><u>Lisa K Stevenson Eden, Md</u>     |                                                                                      |                                                        |

|                                                                                                                                                                                                                                                                                                                                                |  |                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Severe prematurity &amp; severe lung immaturity</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Essentially pre-viable infant</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>3:50 PM - 5:00 PM</u> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|

|                                                                                                                                                                                                                     |                                                  |                                                                                      |                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>On ventilator with high vent settings - pulmonary interstitial emphysema</u> |                                                  |                                                                                      |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |

|                                                                                                                                                          |                                                                        |                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |

|                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                      |                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| 22a. I certify that (I) this hospital attended the deceased from <u>May 30</u> , 19 <u>86</u> , to <u>May 31</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>May 30, 5:00 PM</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                                                                                                                                      | 22c. DATE SIGNED |
| 22b. SIGNATURE<br><u>James D Anthony</u>                                                                                                                                                                                                                                                                                                                                        | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                  |

|                                                                     |                                                    |                                                      |                                                                       |
|---------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------|-----------------------------------------------------------------------|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>James D Anthony</u>     | 22e. ADDRESS<br><u>1279 Meridene Dr. Baltimore</u> |                                                      |                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><u>Burial</u> | 23b. DATE<br><u>June 3, 1986</u>                   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>OLivett</u> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Eden Somerset Md</u> |

|                                                        |                                               |                                                      |                                                             |
|--------------------------------------------------------|-----------------------------------------------|------------------------------------------------------|-------------------------------------------------------------|
| 24. FUNERAL DIRECTOR<br>NAME<br><u>James D Anthony</u> | ADDRESS<br><u>1279 Meridene Dr. Baltimore</u> | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 11, 1986</u> | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Rendore</u> |
|--------------------------------------------------------|-----------------------------------------------|------------------------------------------------------|-------------------------------------------------------------|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, any injury, or other traumatic event, or medical examination, must be notified to the medical examiner.

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "the", "is", "are" are visible.]*

*[Vertical stamp or text, possibly "CHIEF" or "CLERK", oriented vertically along the right edge.]*



00-08243

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8614186

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                                          |                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANNIE - STEWART                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5-28-86                                                                                                              |  | 2b. HOUR<br>12 55 PM                                                                                                                     |                                                 |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br>BLACK                                                                                                                 |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 15 1893                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.                                                                                               |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SC                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                               |                                                 |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BON SECOUR HOSPITAL |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UNEMPLOYED                                                           |                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  |  | 13b. COUNTY                                                                                                                                                 |  | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                           |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ABRAHAM SINGLETON                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MATILDA SINGLETON                                                                                          |  |                                                                                                                                          |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                                                                          |  | 17. INFORMANT<br>ADDRESS<br>FRANCES WASHINGTON 719 APPLETON ST (21217)                                                                                      |  |                                                                                                                                          |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ANOXIC ENCEPHALOPATHY</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CARDIOPULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pneumonia</u> |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                                          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                          |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                          |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/21</u> , 19 <u>86</u> , to <u>5/28</u> , 19 <u>86</u> , that (I) (we) last<br>saw the deceased alive on <u>5/27</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                         |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                                          |                                                 |
| 22b. SIGNATURE<br><u>Arshad Kumar Chopra</u> DEGREE <u>MBBS</u>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>5/28/86</u>                                                                                                       |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>A. K. CHOPRA</u>                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                  |  | 22e. ADDRESS                                                                                                                                                |  |                                                                                                                                          |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br>6/3/86                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL                                                                                                            |  | 23d. LOCATION<br>BALTIMORE COUNTY MD                                                                                                     |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME <u>WM. C. MARCH FUNERAL HOME</u> ADDRESS <u>1101 E. NORTH AVENUE</u>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 2 1986</u>                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>                                                                               |                                                 |

MEDICAL CERTIFICATION

TO HOSPITAL OR TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove complete pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO  
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 CHICAGO, ILL. 60637

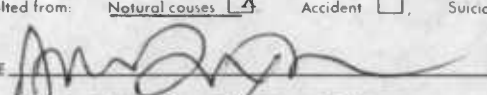
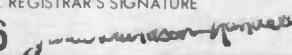


00-06756

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14187

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                     |  |                                                                                                             |  |                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------|--|-------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDWARD STEWART</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                     |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>5 13 1986</b> |  |                                                                               |  | 2b. HOUR<br><b>9:04 P.M.</b>                                                                                                                                                                                                                                                                                                                                                  |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>B</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 18 31 55 YRS.</b>                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b>                                  |  | 7. IF UNDER 1 YR<br>MONTHS DAYS HOURS MIN                                                                                                                                                                                                                                                                                                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW JERSEY</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                               |  |                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                                                                                                                                                                                                                   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                     |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                               |  |                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hosp. (DOA)</b>                                                                                                                                                                                                                               |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BIG B</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>WAREHOUSE</b>                                                       |  |                                                                               |  | 13. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                  |  |
| 13a. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                     |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |                                                                               |  | 13c. STREET ADDRESS<br><b>2799 THE ALEMEDA</b>                                                                                                                                                                                                                                                                                                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES STEWART</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MILDRED JOLLEY</b>                                      |  |                                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>148265718</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                     |  | 17. INFORMANT<br>ADDRESS<br><b>ELAYNE STEWART/LORIS HALL 6113 MAYLANE DR.</b>                               |  |                                                                               |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I                                                                                                                                                                                                                                                                                                                |  |                     |  |                                                                                                             |  |                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                           |  |                                                                               |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                           |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                        |  |                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                                                                                                                                                                                                                                                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                     |  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |                                                                                                                                                                                                                                                                                                                                                                               |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                     |  |                                                                                                             |  |                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                               |  |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                       |  |                     |  | TITLE (SPECIFY)<br><b>Assistant</b> MEDICAL EXAMINER                                                        |  |                                                                               |  | DATE SIGNED<br><b>5-14-86</b>                                                                                                                                                                                                                                                                                                                                                 |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                     |  | ADDRESS<br><b>111 Penn St., Balto., MD 21201</b>                                                            |  |                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                     |  | 23b. DATE<br><b>5-19-86</b>                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>                      |  | 23d. LOCATION<br>CITY COUNTY<br><b>BALTIMORE MARYLAND</b>                                                                                                                                                                                                                                                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WM.C.MARCH F/H INC. 1101 EAST NORTH AVE.</b>                                                                                                                                                                                                                                                                                                                                                       |  |                     |  |                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 16 1986</b>                           |  |                                                                                                                                                                                                                                                                                                                                                                               |  |
| 25b. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                                                           |  |                     |  |                                                                                                             |  |                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                               |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1 AND 2 SHOULD BE USED AS A BURIAL - TRANSFER RECORD. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

00-00150

1

COPIES OF 100

WILLIAM

MAY 18 1988

00-08301

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 1 8 8

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                |                                                                                                                                                             |                                                                                  |                                                                                                              |                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mary</b><br><b>Rosetta M Stine</b>                                                                                                                                                                                                                                                                                                                              |                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/28/86</b>                                                                                                       |                                                                                  | 2b. HOUR<br><b>2:13P</b>                                                                                     |                                                          |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                     | 4. RACE<br><b>C</b>                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 18 13</b>                                                                                                        |                                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.                                                            |                                                          |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                                                 |                                                          |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHS. of MD</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>clerk</b> |                                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>retail sales</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                |                                                                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |                                                                                  | 13e. STREET ADDRESS / ZIP CODE<br><b>1307 W. Church St 21240</b>                                             |                                                          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert Mellott</b>                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ellen Mann</b>                                                                                     |                                                                                  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b> |                                                          |
| 16b. SOCIAL SECURITY NO.<br><b>216-14 6151</b>                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                | 17. INFORMANT<br>ADDRESS<br><b>Roy C. Stine Hagerstown, Md.</b>                                                                                             |                                                                                  |                                                                                                              |                                                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary (Atherosclerosis) Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |                                                                                                                                |                                                                                                                                                             |                                                                                  |                                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><b>Hypertension, Transferred Cell Cancer, Lung Adenocarcinoma</b>                                                                                                                                                                                                |                                                                                                                                |                                                                                                                                                             |                                                                                  |                                                                                                              |                                                          |
| 19a. DATE OF OPERATION<br><b>3/23/86</b>                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Coronary Artery Disease</b>                                                                          |                                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |                                                          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                  |                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                |                                                          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>                                                                                                                                                                                                                                         |                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                            |                                                          |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/23</b> 19 <b>86</b> , to <b>5/28</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/28</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                           |                                                                                                                                |                                                                                                                                                             |                                                                                  |                                                                                                              |                                                          |
| 22b. SIGNATURE<br><b>George J. Grace MD</b>                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                  | 22c. DATE SIGNED<br><b>5/28/86</b>                                                                           |                                                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George J. Grace MD</b>                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                | 22e. ADDRESS<br><b>University of MD Hospital</b>                                                                                                            |                                                                                  |                                                                                                              |                                                          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>burial</b>                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                | 23b. DATE<br><b>May 30, 1986</b>                                                                                                                            |                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Lawn Mem. Park</b>                                            |                                                          |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hagerstown, Wash., Maryland</b>                                                                                                                                                                                                                                                                                                                       |                                                                                                                                | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MINNICH FUNERAL HOME<br/>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>                                          |                                                                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 3 1986</b>                                                           |                                                          |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                |                                                                                                                                                             |                                                                                  |                                                                                                              |                                                          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please remove all blank pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event with medical records, the death certificate must be filed with the State Dept. of Health and Mental Hygiene.





00-08218

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 1 8 9

REG. NO.

|                                           |  |                                                                                                     |  |                                                                                        |  |                                                                        |  |                                       |  |                       |  |                                 |  |                 |  |                 |  |       |  |
|-------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|---------------------------------------|--|-----------------------|--|---------------------------------|--|-----------------|--|-----------------|--|-------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)       |  | FIRST                                                                                               |  | MIDDLE                                                                                 |  | LAST                                                                   |  | 2a. DATE OF DEATH                     |  | MONTH                 |  | DAY                             |  | YEAR            |  | 2b. HOUR        |  | MIN.  |  |
| Eva                                       |  | R                                                                                                   |  | Stirn                                                                                  |  |                                                                        |  | 5-29-86                               |  |                       |  |                                 |  |                 |  | 10 P            |  | M     |  |
| 3. SEX                                    |  | 4. RACE                                                                                             |  | 5. DATE OF BIRTH                                                                       |  | MONTH                                                                  |  | DAY                                   |  | YEAR                  |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  | 7. UNDER 1 YEAR |  | 8. UNDER 24 HRS |  |       |  |
| female                                    |  | white                                                                                               |  | 09                                                                                     |  | 25                                                                     |  | 95                                    |  | 90                    |  | YRS.                            |  | MONTHS          |  | DAYS            |  | HOURS |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) |  | 9b. CITIZEN OF WHAT COUNTRY?                                                                        |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 11. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 12. BALTIMORE CITY OR COUNTY OF DEATH |  | 13. BALTIMORE CITY    |  | 14. MD.                         |  |                 |  |                 |  |       |  |
| Conn                                      |  | USA                                                                                                 |  |                                                                                        |  |                                                                        |  |                                       |  |                       |  |                                 |  |                 |  |                 |  |       |  |
| 10. CITY OR TOWN OF DEATH                 |  | 11. JAMES HOSPITAL NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                          |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |                                       |  |                       |  |                                 |  |                 |  |                 |  |       |  |
| Baltimore City                            |  | 1000 S. Caton Ave. 21229                                                                            |  |                                                                                        |  |                                                                        |  |                                       |  |                       |  |                                 |  |                 |  |                 |  |       |  |
| 13a. STATE                                |  | 13b. COUNTY                                                                                         |  | 13c. CITY OR TOWN                                                                      |  | 13d. INSIDE CITY LIMITS?                                               |  | 13e. STREET ADDRESS / ZIP CODE        |  | 21202                 |  |                                 |  |                 |  |                 |  |       |  |
| Maryland                                  |  |                                                                                                     |  | Baltimore                                                                              |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  | 815 N. Calvert Street                 |  |                       |  |                                 |  |                 |  |                 |  |       |  |
| 14. FATHER'S NAME                         |  | 15. MOTHER'S MAIDEN NAME                                                                            |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                      |  | 16b. SOCIAL SECURITY NO.                                               |  | 17. INFORMANT                         |  | ADDRESS               |  |                                 |  |                 |  |                 |  |       |  |
|                                           |  |                                                                                                     |  |                                                                                        |  | 217-32-9972                                                            |  | John Victor Stirn                     |  | 815 N. Calvert Street |  |                                 |  |                 |  |                 |  |       |  |

|                                                                                                |  |                                              |  |
|------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:                                                                   |  | 3 DAYS                                       |  |
| IMMEDIATE CAUSE (a) HEART FAILURE                                                              |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                 |  | 10 YRS                                       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                              |  |
| (b) HAS CVD                                                                                    |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                 |  |                                              |  |
| (c)                                                                                            |  |                                              |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

|                                                                                                                                                                                                                                                                                                                  |  |                                                                     |  |                                                                                                                                            |  |                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?                                                                                                                              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                  |  |                                                                     |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                |  | 21b. TIME OF INJURY                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                                  |  | HOUR A.M. MONTH DAY YEAR                                            |  |                                                                                                                                            |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                                  |  | P.M. 19                                                             |  |                                                                                                                                            |  |                                                                |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION                                                                                                                              |  | CITY OR TOWN COUNTY STATE                                      |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                              |  |                                                                     |  | STREET                                                                                                                                     |  |                                                                |  |
| 22a. I certify that (this hospital) attended the deceased from FEB 28, 19 86, to MAY 29, 19 86, that (we) last saw the deceased alive on MAY 29, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE                                                      |  | DEGREE                                                                                                                                     |  | 22c. DATE SIGNED                                               |  |
|                                                                                                                                                                                                                                                                                                                  |  | John F. Hartman                                                     |  | M.D.                                                                                                                                       |  | 5-30-86                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                            |  | 22e. ADDRESS                                                        |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                |  |
| JOHN F. HARTMAN, M.D.                                                                                                                                                                                                                                                                                            |  | JENKINS MEMORIAL - 1000 S. CATON AVE 21229                          |  |                                                                                                                                            |  |                                                                |  |

|                                           |  |                          |  |                                    |  |                               |  |                            |  |
|-------------------------------------------|--|--------------------------|--|------------------------------------|--|-------------------------------|--|----------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) |  | 23b. DATE                |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION                 |  | CITY OR TOWN COUNTY STATE  |  |
| burial                                    |  | 06-02-86                 |  | Torraie Park Mausoleum             |  | Woodlawn                      |  | Baltimore MD               |  |
| 24. FUNERAL DIRECTOR                      |  | NAME                     |  | ADDRESS                            |  | 25a. DATE REC'D. BY REGISTRAR |  | 25b. REGISTRAR'S SIGNATURE |  |
| Ambrose Funeral Home                      |  | 1328 Sulphur Spring Road |  |                                    |  | JUN 2 1986                    |  | John Davidson-Randall      |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1, which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

COLLECTION LABELS

WETLANDS



1680-00



0-07746

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (1))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14190

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                          |                                                               |                                                                     |                                                                               |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                          | 2a. DATE KNOWN OF DEATH                                       |                                                                     | 2b. HOUR                                                                      |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                       |                                                          | 2c. DATE ESTIMATED                                            |                                                                     | 2d. HOUR                                                                      |                                              |
| EMMA L STOCKTON                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                          | 5-19-86                                                       |                                                                     | 3:49a                                                                         |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE                                                  | 5. DATE OF BIRTH                                              | 6. AGE (IN YEARS)                                                   | 7. IF UNDER 1 YR                                                              | 8. IF UNDER 24 HRS                           |
| Female                                                                                                                                                                                                                                                                                                                                                                                                                                 | Black                                                    | March 15, 83                                                  | 103 YRS.                                                            |                                                                               |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?                             | 8. MARRIED                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                                                               |                                              |
| N.C.                                                                                                                                                                                                                                                                                                                                                                                                                                   | U.S.A.                                                   | NEVER MARRIED                                                 | Baltimore City                                                      |                                                                               |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                                                               |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                              | 916 Whitelock Street                                     | Domestic                                                      |                                                                     |                                                                               |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                             | 13b. COUNTY                                              | 13c. CITY OR TOWN                                             | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS                                                           |                                              |
| Md                                                                                                                                                                                                                                                                                                                                                                                                                                     | None                                                     | Baltimore                                                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 916 Whitelock St.                                                             | 21217                                        |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                      | 15. MOTHER'S MAIDEN NAME                                 |                                                               |                                                                     |                                                                               |                                              |
| Anderson Dalton                                                                                                                                                                                                                                                                                                                                                                                                                        | Vinnie                                                   |                                                               |                                                                     |                                                                               |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                                                                                                                                                                                                                                                           | 16b. SOCIAL SECURITY NO.                                 | 17. INFORMANT                                                 | ADDRESS                                                             |                                                                               |                                              |
| -----0-----                                                                                                                                                                                                                                                                                                                                                                                                                            | 215-24-3425A                                             | Clara Williams                                                | 916 Whitelock St.                                                   |                                                                               |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                              |                                                          |                                                               |                                                                     |                                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                            |                                                          |                                                               |                                                                     |                                                                               |                                              |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease                                                                                                                                                                                                                                                                                                                                                                            |                                                          |                                                               |                                                                     |                                                                               |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                         |                                                          |                                                               |                                                                     |                                                                               |                                              |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                          |                                                          |                                                               |                                                                     |                                                                               |                                              |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                     |                                                          |                                                               |                                                                     |                                                                               |                                              |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                          |                                                               |                                                                     |                                                                               |                                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I                                                                                                                                                                                                                                                                                                         |                                                          |                                                               |                                                                     |                                                                               |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |                                                                     | 20. AUTOPSY?                                                                  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                          |                                                               |                                                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |                                                          | 21b. TIME OF INJURY                                           |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                          | HOUR A.M. MONTH DAY YEAR                                      |                                                                     |                                                                               |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                          | P.M. 19                                                       |                                                                     |                                                                               |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |                                                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                                                                     | 21f. LOCATION                                                                 |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                          |                                                               |                                                                     | CITY OR TOWN COUNTY STATE                                                     |                                              |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                                          |                                                               |                                                                     |                                                                               |                                              |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                          | TITLE (SPECIFY)                                               |                                                                     | DATE SIGNED                                                                   |                                              |
| Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                                              |                                                          | Assistant                                                     |                                                                     | 5-19-86                                                                       |                                              |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                        |                                                          | ADDRESS                                                       |                                                                     |                                                                               |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                          | 111 Penn Street                                               |                                                                     |                                                                               |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                              |                                                          | 23b. DATE                                                     |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY                                            |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                          | 5/24/86                                                       |                                                                     | Maryland Meme. Park                                                           |                                              |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                          | 23d. LOCATION                                                 |                                                                     | 23e. DATE RECEIVED BY REGISTRAR                                               |                                              |
| NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                          | CITY OR TOWN COUNTY STATE                                     |                                                                     | 23f. REGISTRAR'S SIGNATURE                                                    |                                              |
| Law Funeral Home 4611 Park Heights Ave. 21215                                                                                                                                                                                                                                                                                                                                                                                          |                                                          | Laurel Maryland                                               |                                                                     | MAY 27 1986                                                                   |                                              |

0-01746

2024 NOTICE 1002

UNITED STATES  
MARITIME



1002-1002

00-06646

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 1 9 1

|                                                                                                            |  |                                                                                                                                                  |                                                       |                                                                                                                                                            |  |                                                                                     |  |                                                               |  |
|------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|---------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHN STOKES</b>                                                  |  |                                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 12 86</b> |                                                                                                                                                            |  | 2b. HOUR<br><b>11:45 AM</b>                                                         |  |                                                               |  |
| 3 SEX<br><b>MALE</b>                                                                                       |  | 4 RACE<br><b>B</b>                                                                                                                               |                                                       | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 6 21</b>                                                                                                         |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS                                     |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b> |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Halifax Co., Va.</b>                                        |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                     |                                                       | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.                              |  |                                                               |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL BALTIMORE</b> |                                                       |                                                                                                                                                            |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>       |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>N.Y.</b> |  |                                                                                                                                                  |                                                       | 13b COUNTY<br><b>Brooklyn</b>                                                                                                                              |  | 13c INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13d STREET ADDRESS / ZIP CODE<br><b>1170 Putman Ave 11237</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joe Stokes</b>                                                 |  |                                                                                                                                                  |                                                       | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>L. Ilie Meakes</b>                                                                                      |  |                                                                                     |  |                                                               |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                           |  |                                                                                                                                                  |                                                       | 16b SOCIAL SECURITY NO.<br><b>230-07-6326</b>                                                                                                              |  | 17 INFORMANT<br>ADDRESS<br><b>Mrs. Hottie Williams, 3800 Earton</b>                 |  |                                                               |  |

## MEDICAL CERTIFICATION

|                                                                                                                                                            |  |                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Renal Failure</b>                                                                                           |  |                                                 |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                             |  |                                                 |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Alcoholic cirrhosis &amp; Abscess</b>                                                                             |  |                                                 |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

|                                                                                                                                                                                                                                                                                                                                                              |  |                                                                       |  |                                                                               |  |                                                                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                        |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                      |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |                                                                                                                               |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |                                                                                                                               |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>4-20-</b> 19 <b>86</b> , to <b>5-12</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5-12</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                       |  |                                                                               |  |                                                                                                                               |  |
| 22b SIGNATURE<br><b>Sher A Hashmi</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                       |  | DEGREE<br><b>MD</b>                                                           |  | 22c. DATE SIGNED<br><b>5-12-86</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SHER AFZAL HASHMI</b>                                                                                                                                                                                                                                                                                            |  |                                                                       |  | 22e ADDRESS<br><b>2600 LIBERTY HEIGHTS AVE BALTIMORE</b>                      |  |                                                                                                                               |  |

|                                                                  |  |                            |  |                                                      |  |                                                                   |  |
|------------------------------------------------------------------|--|----------------------------|--|------------------------------------------------------|--|-------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b> |  | 23b DATE<br><b>5-14-86</b> |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Westview</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>James A Morton FH</b>          |  |                            |  | ADDRESS<br><b>101 Laurens St</b>                     |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAY 15 1986</b>                |  |
|                                                                  |  |                            |  | 25b REGISTRAR'S SIGNATURE<br><b>John Darden</b>      |  |                                                                   |  |

BP

FORM 10-60M 7/84  
(MRA 15, 4)

30/1/2000

STREET

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00-08240

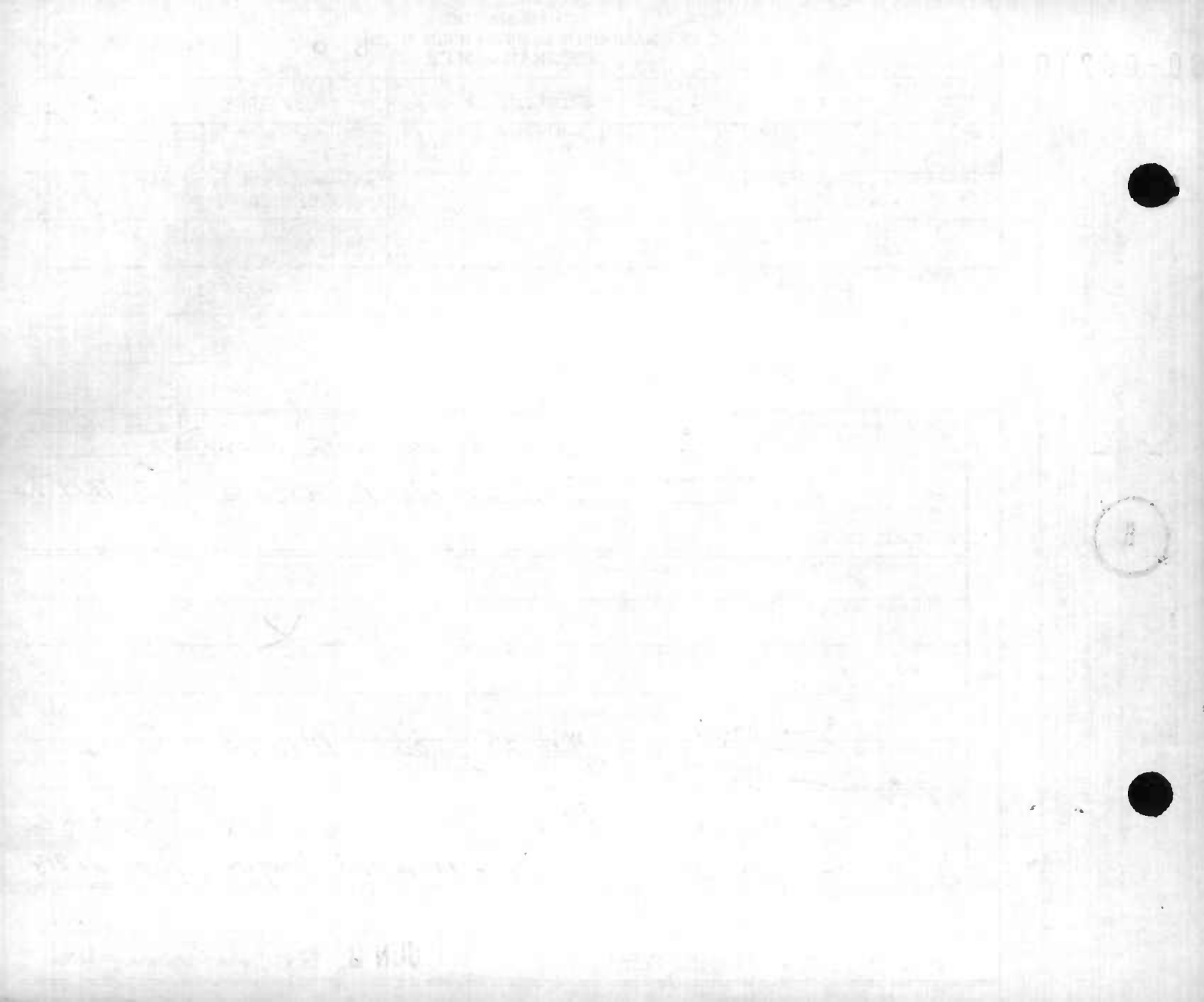
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                         |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     | REG. NO. 6 1 4 1 9 2                                                                                                    |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|-----------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                       |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George T. Strater, Sr.                                                                                                                                                                                                                                    |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     | 2a. DATE OF DEATH MONTH DAY YEAR May 28, 1986                                                                           |  |
| 3. SEX Male                                                                                                                                                                                                                                                                                                  |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     | 2b. HOUR 6:30 A.M.                                                                                                      |  |
| 4. RACE Black                                                                                                                                                                                                                                                                                                |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     | 6. AGE (IN YEARS LAST BIRTHDAY) 67                                                                                      |  |
| 5. DATE OF BIRTH MONTH DAY YEAR 8 1 18                                                                                                                                                                                                                                                                       |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.                                                                                                                                                                                                                                                               |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                                                                 |  |
| 7b. CITIZEN OF WHAT COUNTRY? USA                                                                                                                                                                                                                                                                             |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                     |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) N/A                                                        |  |
| 10. CITY OR TOWN OF DEATH Baltimore                                                                                                                                                                                                                                                                          |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 1917 E. 28th Street                                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 1917 E. 28th St. 21218        |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Willie Strater                                                                                                                                                                                                                                                           |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lessie Allen                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                             |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     | 16b. SOCIAL SECURITY NO. 238-16-6715                                                                                    |  |
| 17. INFORMANT ADDRESS Maxine Grissett 1917 E. 28th St.                                                                                                                                                                                                                                                       |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     |                                                                                                                         |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung with bone and brain metastases (b) and brain metastases (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF                                        |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months                                                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                           |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     |                                                                                                                         |  |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                        |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                       |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                       |  |                                                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                           |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                   |  |                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |                                                     |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT HOME <input type="checkbox"/>                                                                                                                                          |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) hospice                                                                            |  |                                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |                                                     |                                                                                                                         |  |
| 22a. I certify that (this hospital) attended the deceased from May 25, 19 86, to May 28, 19 86, that (we) last saw the deceased alive on May 28, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     |                                                                                                                         |  |
| 22b. SIGNATURE W.B. Daniels, Jr.                                                                                                                                                                                                                                                                             |  |  |  | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                    |  | 22c. DATE SIGNED 5/28/86                                                          |                                                     |                                                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.B. Daniels, Jr.                                                                                                                                                                                                                                                      |  |  |  | 22e. ADDRESS Union Memorial Hospice, Bkth. 21218                                                                                                       |  |                                                    |  |                                                                                   |                                                     |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                             |  |  |  | 23b. DATE 6/3/86                                                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY Church Cemetery |  |                                                                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE Oxford N.C. |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue                                                                                                                                                                                                                                              |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     |                                                                                                                         |  |
| 25. DATE REC'D BY REGISTRAR JUN 2 1986 REGISTRAR'S SIGNATURE John Barker                                                                                                                                                                                                                                     |  |  |  |                                                                                                                                                        |  |                                                    |  |                                                                                   |                                                     |                                                                                                                         |  |



0-06668

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8614193  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                           |  |                                                                                                                                                    |                                                            |                                                                                                                                                                                                                                                                                                                                                                                           |                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>AGNES MABEL STREETT</b>                                                                                                    |  |                                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 10, 1986</b> |                                                                                                                                                                                                                                                                                                                                                                                           | 2b. HOUR<br><b>8:00A</b> M |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                   |  | 4. RACE<br><b>White</b>                                                                                                                            |                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 9, 1901</b>                                                                                                                                                                                                                                                                                                                                |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                      |                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                                                                                                                                                                                                                                                               |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Villa St. Michael Nursing Home</b> |                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                                                                                                                                                                                                                                                                         |                            |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                             |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                    |                                                            | 13c. STREET ADDRESS / ZIP CODE<br><b>440 East 28th Street 21218</b>                                                                                                                                                                                                                                                                                                                       |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ellsworth Tate</b>                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Calder</b>                                                                                |                                                            | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                         |                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>219-12-6474</b>                                                                                                                                            |  | 17. INFORMANT<br>ADDRESS<br><b>Albert Streett 170 Stanmore Road 21212</b>                                                                          |                                                            | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aseptic</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Aspiration pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>                                              |  |                                                                                                                                                    |                                                            |                                                                                                                                                                                                                                                                                                                                                                                           |                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                   |                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5-2 1986</b>                                                                                 |                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                                                            |                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                              |                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                         |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-2 1986</b> , to <b>5-10 1986</b> , that (we) lost the deceased above, (I) (we) did not view the body after death. |  |                                                                                                                                                    |                                                            |                                                                                                                                                                                                                                                                                                                                                                                           |                            |  |
| 22b. SIGNATURE<br><b>Harold B. Bob MD</b>                                                                                                                                                 |  |                                                                                                                                                    |                                                            | 22c. DATE SIGNED<br><b>5-12-86</b>                                                                                                                                                                                                                                                                                                                                                        |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harold B. Bob</b>                                                                                                                             |  |                                                                                                                                                    |                                                            | 22e. ADDRESS<br><b>7220 Park Heights Ave.</b>                                                                                                                                                                                                                                                                                                                                             |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                             |  | 23b. DATE<br><b>5-13-86</b>                                                                                                                        |                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Stabers United Meth.</b>                                                                                                                                                                                                                                                                                                                         |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkton Baltimore Maryland</b>                                                                                                           |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b>                                                        |                                                            |                                                                                                                                                                                                                                                                                                                                                                                           |                            |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1986</b>                                                                                                                                       |  |                                                                                                                                                    |                                                            | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                          |                            |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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100-06758

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

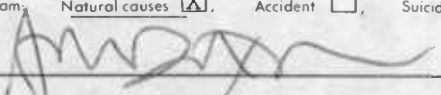
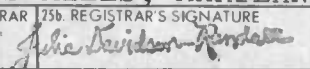
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE MARGINS. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M
 BP \_\_\_\_\_  
 DHMH - 17  
 (VR A15 ME (5))

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

 1. FOR  
 STATE  
 REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                        |                                                                                                             |                                                                                                                                                             |                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HARRY LEE STREET</b>                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                        | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>5 14 1986</b> |                                                                                                                                                             | 2b. HOUR<br>M<br><b>8:02 AM</b>                                 |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                    | 4. RACE<br><b>BLACK</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APR. 20, 1930</b>             | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>56 YRS.</b>                                                      | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN<br><b>5 14 19 86</b>                                                                                             | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>5 14 19 86</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>                                                                                                                                                                                                                                                                                                                                                                       |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |                                                                                                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                 |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                                                                            |                         | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                          |                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b>                     |                                                                 |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SPARROWS POINT</b>                                                                                                                                                                                                                                                                                                                                                   |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STEELWORKER</b>                |                                                                                                             | 13. STREET ADDRESS<br><b>2533 PARK HGHTS. TER. 21215</b>                                                                                                    |                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MARYLAND N/A BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>PEARL T. KATES</b> |                                                                                                             | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES KOREAN</b>                                      |                                                                 |
| 16b. SOCIAL SECURITY NO.<br><b>242-42-8751</b>                                                                                                                                                                                                                                                                                                                                                                                           |                         | 17. INFORMANT<br><b>GLORIA I. STREET</b>                               |                                                                                                             | 17. ADDRESS<br><b>4341 DANLOU DR. 21207</b>                                                                                                                 |                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                            |                         |                                                                        |                                                                                                             |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                           |                         |                                                                        |                                                                                                             |                                                                                                                                                             |                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |                                                                                                             | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                         |                                                                 |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)            |                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                 |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |                                                                        |                                                                                                             |                                                                                                                                                             |                                                                 |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                  |                         | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                     |                                                                                                             | DATE SIGNED <b>5-14-86</b>                                                                                                                                  |                                                                 |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                          |                         | ADDRESS <b>111 Penn St., Balto., MD 21201</b>                          |                                                                                                             |                                                                                                                                                             |                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                            |                         | 23b. DATE<br><b>5/17/86</b>                                            |                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARRISON FOREST VA.</b>                                                                                            |                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LERROY O. DYETT</b>                                                                                                                                                                                                                                                                                                                                                                                   |                         | ADDRESS<br><b>4600 LIB. HGHTS. AVE.</b>                                |                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 16 1986</b>                                                                                                         |                                                                 |
| 25b. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                                                      |                         |                                                                        |                                                                                                             |                                                                                                                                                             |                                                                 |



00-07830

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14195

1- FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                              |                                                      |                                                                                                                                                            |                         |                                                                                                                           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Hazel Strickland</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                              | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/22/86</b> |                                                                                                                                                            | 2b HOUR<br>M<br><b></b> |                                                                                                                           |  |
| 3 SEX<br><b>Fe</b>                                                                                                                                                                                                                                                                                                                                                   |  | 4 RACE<br><b>B</b>                                                                                                           |                                                      | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 16 1927</b>                                                                                                      |                         | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>58</b>                                                |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Alabama</b>                                                                                                                                                                                                                                                                                                           |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                 |                                                      | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                         | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.                                                                    |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto</b>                                                                                                                                                                                                                                                                                                                             |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident</b> |                                                      | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                                                        |                         | 12b KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                              |  | 13b COUNTY<br><b>Balto.</b>                                                                                                  |                                                      | 13c CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |                         | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ellis Gandy</b>                                                                                                                                                                                                                                                                                                          |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosa L. Laster</b>                                                        |                                                      | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>                                                                              |                         |                                                                                                                           |  |
| 16b SOCIAL SECURITY NO.<br><b>350 22 6104</b>                                                                                                                                                                                                                                                                                                                        |  | 17 INFORMANT ADDRESS<br><b>Morris Strickland 2310 Allendale</b>                                                              |                                                      |                                                                                                                                                            |                         |                                                                                                                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Probable Brain Metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>6 months</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> |  |                                                                                                                              |                                                      |                                                                                                                                                            |                         |                                                                                                                           |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b></b>                                                                                                                                                                                                                          |  |                                                                                                                              |                                                      |                                                                                                                                                            |                         |                                                                                                                           |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                              |                                                      | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                         | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                             |                                                      | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                         |                                                                                                                           |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                             |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                        |                                                      | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                         |                                                                                                                           |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>5</b> 19 <b>86</b> , to <b>5</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>5</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |  |                                                                                                                              |                                                      |                                                                                                                                                            |                         |                                                                                                                           |  |
| 22b SIGNATURE<br><b>Philip Konits MD.</b>                                                                                                                                                                                                                                                                                                                            |  | DEGREE                                                                                                                       |                                                      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |                         | 22c DATE SIGNED<br><b>5/27/86</b>                                                                                         |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Philip Konits MD.</b>                                                                                                                                                                                                                                                                                                     |  | 22e ADDRESS                                                                                                                  |                                                      |                                                                                                                                                            |                         |                                                                                                                           |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                         |  | 23b DATE<br><b>5/29/86</b>                                                                                                   |                                                      | 23c NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>                                                                                                     |                         | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                                           |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Jas. A. Morton &amp; Sons 1701 Laurens St.</b>                                                                                                                                                                                                                                                                                     |  |                                                                                                                              |                                                      | 25 DATE REC'D. BY REGISTRAR<br><b>MAY 28 1986</b>                                                                                                          |                         |                                                                                                                           |  |

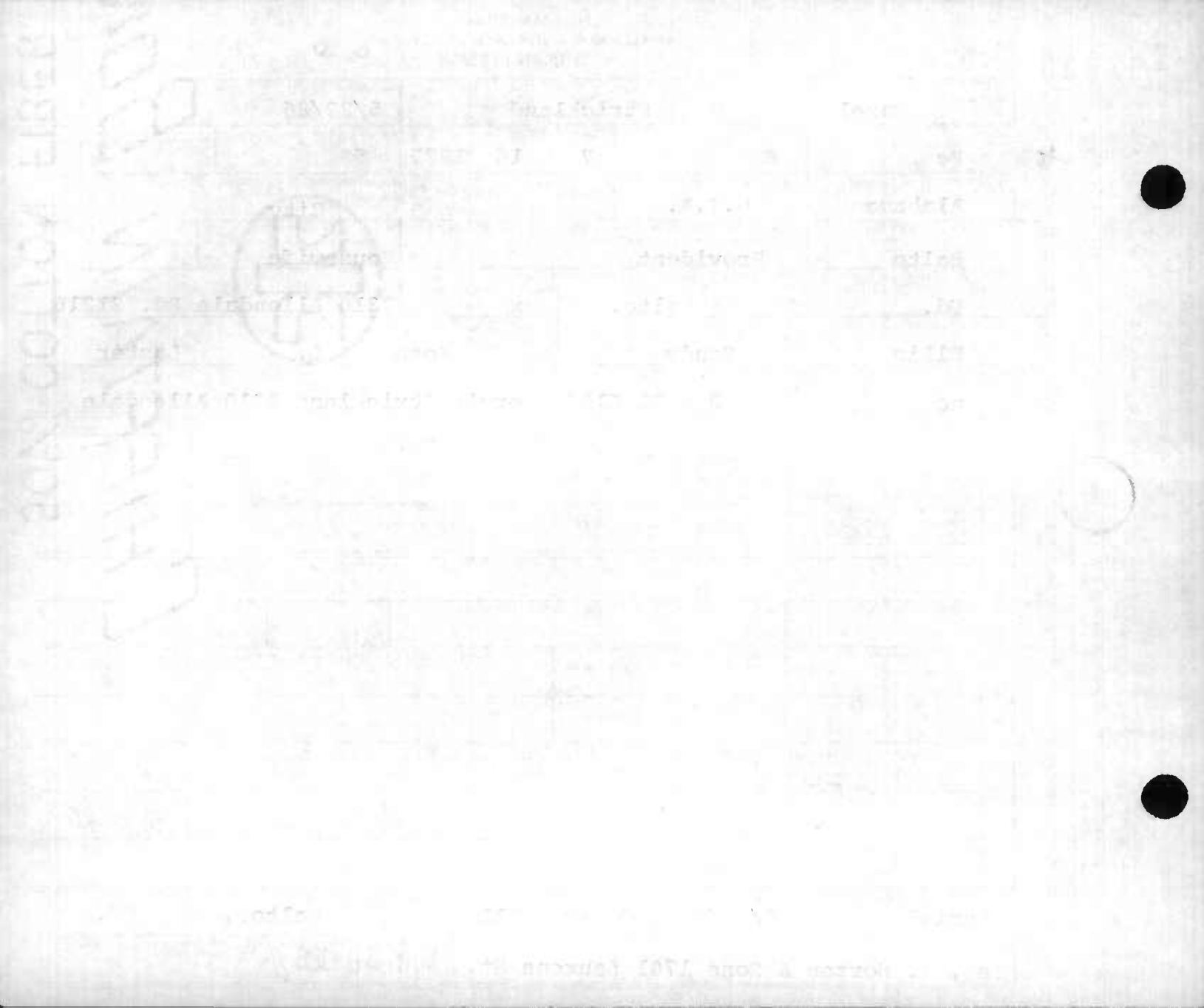
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use on the burial-transit permit. Their places should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows, only injury, or other traumatic event, the medical examiner must be notified at once.





00-08059

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14196

|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1- FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                |  | REG. NO.                                                                                                                                                    |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                          |  | 2a DATE OF DEATH                                                                                                                                            |  |
| SARAH M. STUBBINS                                                                                                                                                                                                                                                                                                           |  | 05/27/86                                                                                                                                                    |  |
| 3 SEX                                                                                                                                                                                                                                                                                                                       |  | 2b HOUR                                                                                                                                                     |  |
| FEMALE                                                                                                                                                                                                                                                                                                                      |  | 11:15am                                                                                                                                                     |  |
| 4 RACE                                                                                                                                                                                                                                                                                                                      |  | 5. DATE OF BIRTH                                                                                                                                            |  |
| WHITE                                                                                                                                                                                                                                                                                                                       |  | MONTH DAY YEAR                                                                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                             |  | 3 4 07                                                                                                                                                      |  |
| 6a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                    |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                                                                                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                                    |  | 79 YRS                                                                                                                                                      |  |
| 7b CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| U.S.A.                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                             |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                                                                                                                                                                                         |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                |  |
| BALTIMORE CITY MD.                                                                                                                                                                                                                                                                                                          |  | Homemaker                                                                                                                                                   |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                   |  | 12b KIND OF BUSINESS OR INDUSTRY                                                                                                                            |  |
| BALTIMORE CITY                                                                                                                                                                                                                                                                                                              |  | ---                                                                                                                                                         |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                                                                                                                                                                                      |  | 13a STREET ADDRESS / ZIP CODE                                                                                                                               |  |
| ST. AGNES HOSPITAL                                                                                                                                                                                                                                                                                                          |  | 3322 Washington Blvd. 21227                                                                                                                                 |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                  |  | 13b. CITY OR TOWN                                                                                                                                           |  |
| Maryland                                                                                                                                                                                                                                                                                                                    |  | Lansdowne                                                                                                                                                   |  |
| 13c. CITY OR TOWN                                                                                                                                                                                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                         |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                    |  |
| BENJAMIN MIDDLE LAST                                                                                                                                                                                                                                                                                                        |  | MARATHA MIDDLE LAST                                                                                                                                         |  |
| Benjamin Roberts                                                                                                                                                                                                                                                                                                            |  | Maratha Gerber                                                                                                                                              |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                            |  | 16b SOCIAL SECURITY NO.                                                                                                                                     |  |
| NO                                                                                                                                                                                                                                                                                                                          |  | 219-28-4388                                                                                                                                                 |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                               |  | ADDRESS                                                                                                                                                     |  |
| Frank E. Stubbins, Sr.                                                                                                                                                                                                                                                                                                      |  | 21227 3322 Washington Blvd.                                                                                                                                 |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                             |  |
| IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                             |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                             |  |
| (b) <u>SEPSIS, PROBABLE CHOLANGITIS</u>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                             |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                             |  |
| (c)                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                             |  |                                                                                                                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                             |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                         |  |
| 21a. INJURY OCCURRED                                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY                                                                                                                                         |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                           |  | HOUR A.M. MONTH DAY YEAR                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                             |  | P.M. 19                                                                                                                                                     |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)                                                                                                                                                                                                                                               |  | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                             |  |
| 21e. LOCATION                                                                                                                                                                                                                                                                                                               |  | 21f. LOCATION                                                                                                                                               |  |
| CITY OR TOWN                                                                                                                                                                                                                                                                                                                |  | COUNTY STATE                                                                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE                                                                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                             |  | DEGREE                                                                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                             |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |
| 22c. DATE SIGNED                                                                                                                                                                                                                                                                                                            |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                       |  |
| 5-27-86                                                                                                                                                                                                                                                                                                                     |  | R MALHOTRA, M.D.                                                                                                                                            |  |
| 22e. ADDRESS                                                                                                                                                                                                                                                                                                                |  | 22f. ADDRESS                                                                                                                                                |  |
| ST. AGNES HOSP, 900 CATON AVE, BALTIMORE, MD 21229                                                                                                                                                                                                                                                                          |  |                                                                                                                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                   |  | 23b. DATE                                                                                                                                                   |  |
| Burial                                                                                                                                                                                                                                                                                                                      |  | 5/30/86                                                                                                                                                     |  |
| 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                                          |  | 23d. LOCATION                                                                                                                                               |  |
| Loudon park Cemetery                                                                                                                                                                                                                                                                                                        |  | BALTIMORE COUNTY STATE                                                                                                                                      |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |  |
| NAME ADDRESS                                                                                                                                                                                                                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |  |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229                                                                                                                                                                                                                                                                          |  | MAY 29 1986                                                                                                                                                 |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

10000-0

10000-0

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00-07707

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 14197  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          |                                                           |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ANNA IRENE SUEC</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 26 1986</b> |                                                                                                                                                              |  | 2b. HOUR<br><b>945 A.M.</b>                                                                     |  |                                                                                                                            |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>CAUCASION</b>                                                                                                              |                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 9 1900</b>                                                                                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.                                               |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                |                                                           | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                              |  |                                                                                                                            |  |
| 12. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSP.</b> |                                                           |                                                                                                                                                              |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salad Maker</b>           |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>Hasslinger Co</b>                                                                   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY                                                                                                                              |                                                           | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                        |  | 13d. INSIDE-CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3435 MAYFIELD AVE, 21213</b>                                                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis White</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Flaherty</b>                                                                                        |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>--</b>                                                                     |                                                           | 17. INFORMANT ADDRESS<br><b>Doris Susemihl same address</b>                                                                                                  |  |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY ARTERY DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                          |                                                           |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>o</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |                                                           |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |                                                           |                                                                                                                                                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                               |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                            |  |                                                                                                 |  |                                                                                                                            |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>MAY 20 19 86</b> to <b>MAY 26 19 86</b> , that (I) (we) lost<br>saw the deceased alive on <b>MAY 25 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                   |  |                                                                                                                                          |                                                           |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. SIGNATURE<br><b>Ranjiv Kumar Saini MD</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          |                                                           | DEGREE<br><b>MD</b>                                                                                                                                          |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>5/26/86</b>                                                                                         |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RANJIV KUMAR SAINI M.D.</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |                                                           | 22e. ADDRESS<br><b>GOOD SAMARITAN HOSP. BALTIMORE</b>                                                                                                        |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>5-29-86</b>                                                                                                              |                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                |  |                                                                                                                            |  |
| 24. FUNERAL HOME<br><b>Schummeek Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |                                                           | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 27 1986</b>                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                |  |                                                                                                                            |  |
| 24a. ADDRESS<br><b>3331 Brehms Lane Balto., Md. 21213</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |                                                           |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |

BP

CO-000001



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00-08535

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on by law.

|                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                                                                                           |                                                                                     |                                                                           |                                                                           |                                                                                                                            |                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                                                                                           |                                                                                     |                                                                           |                                                                           |                                                                                                                            | 6 1 4 1 9 8                                  |  |
| 1 - STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                                                                                           |                                                                                     |                                                                           |                                                                           |                                                                                                                            | REG. NO.                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Annie Sullivan</i>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>5 31 86</i>                                                                                                                     |                                                                                     |                                                                           | 2b. HOUR<br><i>5:2</i> M                                                  |                                                                                                                            |                                              |  |
| 3. SEX<br><i>F</i>                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><i>B</i>                                                                                                                |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>11 17 00</i>                                                                                                       |                                                                                                                                                                           |                                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>85</i> YRS                          |                                                                           | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>North Carolina</i>                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                      |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH.<br><i>Baltimore</i> MD.                       |                                                                           |                                                                           |                                                                                                                            |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lutheraan Hosp</i> |                                                                        |                                                                                                                                                             |                                                                                                                                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Domestic</i> |                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY                                         |                                                                                                                            |                                              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                            |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | 13b. COUNTY                                                                                                                                                               |                                                                                     | 13c. CITY OR TOWN<br><i>Baltimore</i>                                     |                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>George Knockett</i>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mary Davis</i>                                                                                                        |                                                                                     |                                                                           |                                                                           |                                                                                                                            |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>217-22-3099-4</i>                                                    |                                                                        | 17. INFORMANT<br>ADDRESS<br><i>George Knockett 1024 N. Bentalou St. 21216</i>                                                                               |                                                                                                                                                                           |                                                                                     |                                                                           |                                                                           |                                                                                                                            |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>CHF</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>? left ventricular</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                                                                                           |                                                                                     |                                                                           |                                                                           |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a                                                                                                                                                                                                                                  |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                                                                                           |                                                                                     |                                                                           |                                                                           |                                                                                                                            |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                                                           |                                                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                            |  |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>           |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                            |                                                                                     |                                                                           |                                                                           |                                                                                                                            |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                           |  |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                         |                                                                                     |                                                                           |                                                                           |                                                                                                                            |                                              |  |
| 22a. I certify that I (this hospital) attended the deceased from <i>5/29/86</i> 19 <i>86</i> , to <i>5/31</i> 19 <i>86</i> , that (we) last saw the deceased alive on <i>5/31/86</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.            |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                                                                                           |                                                                                     |                                                                           |                                                                           |                                                                                                                            |                                              |  |
| 22b. SIGNATURE<br><i>Sam Amick</i>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | DEGREE <i>MD</i><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                     |                                                                           |                                                                           |                                                                                                                            | 22c. DATE SIGNED<br><i>5/31/86</i>           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>SISSAY Amick</i>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><i>Lutheraan Hospital</i>                                                                                                                                 |                                                                                     |                                                                           |                                                                           |                                                                                                                            |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    | 23b. DATE<br><i>6-5-86</i>                                             |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cemetery</i>                                                                                                          |                                                                                     |                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Glen Burnie Maryland</i> |                                                                                                                            |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Bailey Funeral Home</i>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | ADDRESS<br><i>1348 N. Calhoun St. 21217</i>                                                                                                                               |                                                                                     | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 5 1986</i>                        |                                                                           | 25b. REGISTRAR'S SIGNATURE<br><i>John M. ...</i>                                                                           |                                              |  |

SECRET

SECRET



SECRET



00-008427

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |                                                                          |                                                                                                                                                            |                                                                                     |                                                                                                |                                                                                                                                       |                                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDYTHE MARILYN SUSHELKY</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 31, 1986</b>                |                                                                                                                                                            |                                                                                     | 2b HOUR<br>A<br><b>7:00 M</b>                                                                  |                                                                                                                                       |                                                                             |  |
| 3 SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                           |  | 4 RACE<br><b>WHITE</b>                                                                                                                           |                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOV. 28, 1940</b>                                                                                                 |                                                                                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>45</b> YRS.                                               |                                                                                                                                       | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                              |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                      |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                        |                                                                          | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                               |                                                                                                                                       |                                                                             |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>17 COBBLESTONE CT., APT. T-2</b> |                                                                          | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MAINTENANCE OF LIFE)<br><b>OFFICER COMMUNICATIONS</b>                                                            |                                                                                     | 12b KIND OF BUSINESS OR INDUSTRY<br><b>MD. STATE POLICE</b>                                    |                                                                                                                                       |                                                                             |  |
| 13a STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                     |  | 13b COUNTY<br><b>BALTIMORE</b>                                                                                                                   |                                                                          | 13c CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |                                                                                     | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                       | 13e STREET ADDRESS / ZIP CODE<br><b>17 COBBLESTONE CT., APT. T-2 #21215</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE E. ELGIN</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>GERTRUDE NORWITZ</b> |                                                                                                                                                            |                                                                                     |                                                                                                |                                                                                                                                       |                                                                             |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                 |  | 16b SOCIAL SECURITY NO.<br><b>220-36-8361</b>                                                                                                    |                                                                          | 17 INFORMANT<br><b>MR. GEORGE E. ELGIN</b>                                                                                                                 |                                                                                     | ADDRESS<br><b>17 COBBLESTONE CT., APT. T-2 #21215</b>                                          |                                                                                                                                       |                                                                             |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b>                                                                                                                                                                                                   |  |                                                                                                                                                  |                                                                          |                                                                                                                                                            |                                                                                     |                                                                                                |                                                                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>NONE</b>                 |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>BRAINSTEM COMPRESSION</b>                                                                                                                                                                                                                                |  |                                                                                                                                                  |                                                                          |                                                                                                                                                            |                                                                                     |                                                                                                |                                                                                                                                       | <b>2 HRS</b>                                                                |  |
| (c) <b>RIGHT FRONTAL GLIOBLASTOMA MULTIFORME</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |                                                                          |                                                                                                                                                            |                                                                                     |                                                                                                |                                                                                                                                       | <b>2 years</b>                                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>NONE</b>                                                                                                                                                                                                                   |  |                                                                                                                                                  |                                                                          |                                                                                                                                                            |                                                                                     |                                                                                                |                                                                                                                                       |                                                                             |  |
| 19a DATE OF OPERATION<br><b>2/85</b>                                                                                                                                                                                                                                                                                                                             |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Right glioblastoma debulking</b>                                                           |                                                                          |                                                                                                                                                            | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                             |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                 |                                                                          | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                     |                                                                                                |                                                                                                                                       |                                                                             |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                         |  | 21e PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                             |                                                                          | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                     |                                                                                                |                                                                                                                                       |                                                                             |  |
| 22a I certify that (1) (this hospital) attended the deceased from <b>March</b> 19 <b>86</b> to <b>April</b> 19 <b>86</b> , that (2) (we) last saw the deceased alive on <b>April</b> 19 <b>86</b> , and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above; (4) (we) (did) (did not) view the body after death. |  |                                                                                                                                                  |                                                                          |                                                                                                                                                            |                                                                                     |                                                                                                |                                                                                                                                       |                                                                             |  |
| 22b SIGNATURE<br><b>John Aryanpur</b>                                                                                                                                                                                                                                                                                                                            |  | DEGREE<br><b>MD</b>                                                                                                                              |                                                                          | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |                                                                                     |                                                                                                | 22c DATE SIGNED<br><b>5/31/86</b>                                                                                                     |                                                                             |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN ARYANPUR, M.D.</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  |                                                                          | 22e ADDRESS<br><b>JOHNS HOPKINS HOSPITAL BALTO MD</b>                                                                                                      |                                                                                     |                                                                                                |                                                                                                                                       |                                                                             |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                        |  | 23b DATE<br><b>6-1-86</b>                                                                                                                        |                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SHAAREI ZION CONG.</b>                                                                                            |                                                                                     | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b>                         |                                                                                                                                       |                                                                             |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |                                                                          | 24b ADDRESS<br><b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>                                                                                              |                                                                                     | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 4 1986</b>                                              |                                                                                                                                       | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                             |  |

MEDICAL CERTIFICATION

2  
2

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP



00-08017

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14199

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                         |                                                                                                                                          |                                                                 |  |                                                                                                                                                             |  |                                                     |                                                                                                                                       |                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR FIRST) <b>RAYMOND</b> <b>SULLIVAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>28</b> YEAR <b>86</b>                                                                         |                                                                 |  | 2b. HOUR<br><b>6:28</b> AM                                                                                                                                  |  |                                                     |                                                                                                                                       |                                                    |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>BLACK</b> |                                                                                                                                          | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>15</b> YEAR <b>17</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS                                                                                                            |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |                                                                                                                                       | 8. IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                     |                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |                                                                 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>                                                                          |  |                                                     | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                     |                                                    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                                                                                                                                                                                                              |  |                         |                                                                                                                                          |                                                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |                                                     | 13e. STREET ADDRESS / ZIP CODE<br><b>701 N. Arlington Ave. 21217</b>                                                                  |                                                    |  |
| 14. FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>Floyd</b> LAST <b>FLOYD</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                         |                                                                                                                                          |                                                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Martha</b> MIDDLE <b>FLOYD</b> LAST <b>FLOYD</b>                                                                       |  |                                                     |                                                                                                                                       |                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>M.W. 2 217-07-6721</b>                                                      |                                                                 |  | 17. INFORMANT<br><b>Roberta S. Peyton</b>                                                                                                                   |  |                                                     | ADDRESS<br><b>RT. 1 Box 1112 King George, Va. 22485</b>                                                                               |                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest c anoxic encephalopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Chronic gastric ulcer c massive upper GI bleeding</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b> |  |                         |                                                                                                                                          |                                                                 |  |                                                                                                                                                             |  |                                                     |                                                                                                                                       |                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)<br><b>CA Duodenum, CHF, COPD, Diabetes &amp; nephrotic Syndrome</b>                                                                                                                                                                                                                                                                                            |  |                         |                                                                                                                                          |                                                                 |  |                                                                                                                                                             |  |                                                     |                                                                                                                                       |                                                    |  |
| 19a. DATE OF OPERATION<br><b>5/2/86 &amp; 5/16/86</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>OCA duodenum @ GI bleed</b>                                                       |                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                           |  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                        |                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                     |                                                                                                                                       |                                                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                          |  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |                                                                 |  | 21f. LOCATION<br>STREET <b>1190 W. Northern Pkwy</b> CITY OR TOWN <b>21210</b> COUNTY <b>A.A.</b> STATE <b>Md.</b>                                          |  |                                                     |                                                                                                                                       |                                                    |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4/25/86</b> to <b>5/28/86</b> , that (I) (we) lost soul the deceased alive on <b>5/28</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                                             |  |                         |                                                                                                                                          |                                                                 |  |                                                                                                                                                             |  |                                                     |                                                                                                                                       |                                                    |  |
| 23a. SIGNATURE<br><b>J. Singh MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                         |                                                                                                                                          |                                                                 |  | DEGREE<br><b>MD</b>                                                                                                                                         |  |                                                     | 22c. DATE SIGNED<br><b>MAY 29 1986</b>                                                                                                |                                                    |  |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOGENDRA SINGH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                         |                                                                                                                                          |                                                                 |  | 22e. ADDRESS<br><b>1190 W. Northern Pkwy, 21210</b>                                                                                                         |  |                                                     |                                                                                                                                       |                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                         | 23b. DATE<br><b>6/2/86</b>                                                                                                               |                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran Cem.</b>                                                                                               |  |                                                     | 23d. LOCATION<br>CITY OR TOWN <b>Crownsville</b> COUNTY <b>A.A.</b> STATE <b>Md.</b>                                                  |                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Chas. A. Rice</b> ADDRESS <b>FSPA 1300 Eutaw Place</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                         |                                                                                                                                          |                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 29 1986</b>                                                                                                         |  |                                                     | 25b. REGISTRAR'S SIGNATURE<br><b>Jana Davidson</b>                                                                                    |                                                    |  |

MEDICAL CERTIFICATION

99

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1080-00



RECEIVED

00-06383

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                     |                                                                     |                                                                                                                                                             |                                                                                                                                                             |                                                                                              |  |                                                                                                                         |  |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                          |  |                                                                                                                                     |                                                                     |                                                                                                                                                             |                                                                                                                                                             |                                                                                              |  |                                                                                                                         |  | 8614201                                      |  |
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                        |  | REG. NO.                                                                                                                            |                                                                     |                                                                                                                                                             |                                                                                                                                                             |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Helen R Suter</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5 7 86</b>                                                                                                           |                                                                                              |  | 2b. HOUR<br><b>10:20pm</b>                                                                                              |  |                                              |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>White</b>                                                                                                             |                                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 13, 1920</b>                                                                                                     |                                                                                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                            |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                              |  |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                       |                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |  |                                                                                                                         |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |                                                                     |                                                                                                                                                             |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Davidson Truck Co</b>                                                           |  |                                              |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY<br><b>Cecil</b>                                                                                                         |                                                                     | 13c. CITY OR TOWN<br><b>Port Deposit</b>                                                                                                                    |                                                                                                                                                             | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                                                                                         |  |                                              |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>67 Remington Road 21904</b>                                                                                                                                                                                                                                                                                                              |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Herbert G. Groff</b>                                                                      |                                                                     | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Iva B. Jones</b>                                                                                           |                                                                                                                                                             |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br><b>167-144027</b>                                                                                       |                                                                     | 17. INFORMANT ADDRESS<br><b>Donald R. Suter, Port Deposit, Maryland.</b>                                                                                    |                                                                                                                                                             |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BACTEREMIA - E. coli</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>PYELONEPHRITIS - E. coli</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                     |                                                                     |                                                                                                                                                             |                                                                                                                                                             |                                                                                              |  |                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                         |  |                                                                                                                                     |                                                                     |                                                                                                                                                             |                                                                                                                                                             |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                             |                                                                                                                                                             | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                            |  |                                                                                                                                     | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |                                                                                                                         |  |                                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                        |  |                                                                                                                                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                                                                                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                         |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                   |  |                                                                                                                                     |                                                                     |                                                                                                                                                             |                                                                                                                                                             |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 22b. SIGNATURE<br><b>Michael E. Pelczar</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                     |                                                                     |                                                                                                                                                             | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                              |  |                                                                                                                         |  | 22c. DATE SIGNED<br><b>5/8/86</b>            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL E. PELCZAR MD</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                     |                                                                     |                                                                                                                                                             | 22e. ADDRESS<br><b>900 S. Caton Avenue Balto. Md. 21229</b>                                                                                                 |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     | 23b. DATE<br><b>May 11, 1986</b>                                    |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>West Nottingham Cem.</b>                                                                                           |                                                                                              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Colona, Cecil, Maryland</b>                                               |  |                                              |  |
| 24. FUNERAL DIRECTOR<br><b>Lee A. Patterson &amp; Son</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |                                                                     |                                                                                                                                                             | ADDRESS<br><b>Perryville, Maryland.</b>                                                                                                                     |                                                                                              |  | 25. DATE REC'D. BY REGISTRAR (I) REGISTRAR'S SIGNATURE<br><b>MAY 13 1986</b> <b>John Davidson-Randall</b>               |  |                                              |  |



00-06371

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHRelease on Application  
8-6-86 142502

REG. NO.

|                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                       |                                                   |                                                                                                                                                             |  |                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Walter L Sutton                                                                                 |  |                                                                                                                                                                                                                                                                                                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 / 9 / 86 |                                                                                                                                                             |  | 2b. HOUR<br>0050 PM                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                |  |
| 3. SEX<br>Male                                                                                                                                           |  | 4. RACE<br>White                                                                                                                                                                                                                                                                                                      |                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 29 01                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 (YRS)                                                                                                                                          |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                                                                                                                                                                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                                |                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Seneca Hospital of Baltimore                                                                                                                                                                             |                                                   |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired-B. & O. R. H.                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                              |  |
| 13a. STATE<br>Maryland                                                                                                                                   |  | 13b. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                                              |                                                   | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  | 13e. STREET ADDRESS / ZIP CODE<br>2202 Ridge Road #21136                                                                                                                                                                                                                                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter P Reisterstown                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lillie Tolle                                                                                                                                                                                                                                                         |                                                   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                       |  | 17. INFORMANT<br>30 Arkla Ct. Baltimore, Md.<br>Rev. C. Robert Sutton #21228                                                                                                         |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Cardio Respiratory Failure<br>888<br>DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Embolism<br>Approx 35 days<br>Approx 30 days |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                       |  |                                                                                                                                                                                                                                                                                                                       |                                                   |                                                                                                                                                             |  |                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                |  |
| 19a. DATE OF OPERATION<br>4/9/86                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Green Field Umbrella Invention                                                                                                                                                                                                                                    |                                                   |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>3:19 P.M. 3 23 86                                                                                                                                                                                                                                                  |                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>Falling Injury                                                            |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>Unknown                                                                                                                                                                                                                              |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Unknown                                                                                             |  | 22a. I certify that (I) (this hospital) attended the deceased from March 23, 1986, to May 9, 1986, that (I) (we) last saw the deceased alive on May 9, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                   |                                                                                                                                                             |  |                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                |  |
| 22b. SIGNATURE<br>Thomas Kunisaki MD                                                                                                                     |  | 22c. DATE SIGNED<br>5/9/86                                                                                                                                                                                                                                                                                            |                                                   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thomas Kunisaki                                                                                                    |  | 22e. ADDRESS<br>Sinai Hospital                                                                                                                                                       |  | 22f. MEDICAL ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation                                                                                                   |  | 23b. DATE<br>5-9-86                                                                                                                                                                                                                                                                                                   |                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Pk. Cem                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.                                                                                                                             |  | 24. FUNERAL DIRECTOR<br>NAME<br>G. Truman Setwab                                                                                                                                                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. Truman Setwab                                                                                                         |  | 24b. ADDRESS<br>3312 Frederick Ave. # 21229                                                                                                                                                                                                                                                                           |                                                   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 13 1986                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                |  |

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SUTTON WALTER L.  
03/23/86 JUANTEGUY JUAN M  
2202 RIDGE RD.  
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#18a, Form G617 7/18/86

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

- 14203

REG. NO.

|                                                                                                                                     |         |                                                                                                                                                                                                      |  |                                                                                                                                                          |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
|-------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|-------------------------------------|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                 |         | FIRST                                                                                                                                                                                                |  | MIDDLE                                                                                                                                                   |  | LAST                                                                |  | 2b. DATE KNOWN OF DEATH MATED       |  | MONTH                    |  | DAY   |  | YEAR |  | 2c. HOUR |  |
| DR. JAMES T. SYGENDA, JR.                                                                                                           |         |                                                                                                                                                                                                      |  |                                                                                                                                                          |  |                                                                     |  | <input checked="" type="checkbox"/> |  | 5/5/19                   |  | 86    |  |      |  | M        |  |
| 3. SEX                                                                                                                              | 4. RACE | 5. DATE OF BIRTH                                                                                                                                                                                     |  | 6. AGE (IN YEARS)                                                                                                                                        |  | IF UNDER 1 YR                                                       |  | IF UNDER 24 HRS                     |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| M                                                                                                                                   | W       | 4/3/57                                                                                                                                                                                               |  | 29                                                                                                                                                       |  | YRS.                                                                |  |                                     |  | 5/5/1986                 |  |       |  |      |  | 8:23 P M |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                           |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                     |  |                          |  |       |  |      |  |          |  |
| Illinois                                                                                                                            |         | USA                                                                                                                                                                                                  |  |                                                                                                                                                          |  | Baltimore City, MD.                                                 |  |                                     |  |                          |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                           |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                     |  |                          |  |       |  |      |  |          |  |
| Baltimore                                                                                                                           |         | Sinai Hospital                                                                                                                                                                                       |  | Physician                                                                                                                                                |  | Medical                                                             |  |                                     |  |                          |  |       |  |      |  |          |  |
| 13a. STATE                                                                                                                          |         | 13b. COUNTY                                                                                                                                                                                          |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                 |  |                          |  |       |  |      |  |          |  |
| MD                                                                                                                                  |         |                                                                                                                                                                                                      |  | Balto.                                                                                                                                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | Apt. 101<br>2229 Rogene Dr., 21209  |  |                          |  |       |  |      |  |          |  |
| 14. FATHER'S NAME                                                                                                                   |         | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                             |  |                                                                                                                                                          |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| James T. Sygenda, Sr.                                                                                                               |         | Laverne Cudnowski                                                                                                                                                                                    |  |                                                                                                                                                          |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                  |         | 16b. SOCIAL SECURITY NO.                                                                                                                                                                             |  | 17. INFORMANT                                                                                                                                            |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| No                                                                                                                                  |         | 253 08 0566                                                                                                                                                                                          |  | Julie Sygenda, Holland, PA 18966                                                                                                                         |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                           |         | 19. DATE OF OPERATION                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                        |  | 20. AUTOPSY?                                                        |  |                                     |  |                          |  |       |  |      |  |          |  |
| PART I DEATH WAS CAUSED BY:                                                                                                         |         |                                                                                                                                                                                                      |  |                                                                                                                                                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                     |  |                          |  |       |  |      |  |          |  |
| IMMEDIATE CAUSE (a)                                                                                                                 |         |                                                                                                                                                                                                      |  |                                                                                                                                                          |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                      |         |                                                                                                                                                                                                      |  |                                                                                                                                                          |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |         |                                                                                                                                                                                                      |  |                                                                                                                                                          |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| (b)                                                                                                                                 |         |                                                                                                                                                                                                      |  |                                                                                                                                                          |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                      |         |                                                                                                                                                                                                      |  |                                                                                                                                                          |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| (c)                                                                                                                                 |         |                                                                                                                                                                                                      |  |                                                                                                                                                          |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |         |                                                                                                                                                                                                      |  |                                                                                                                                                          |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH      |         | 21b. TIME OF INJURY                                                                                                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
|                                                                                                                                     |         | HOUR A.M. MONTH DAY YEAR                                                                                                                                                                             |  |                                                                                                                                                          |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
|                                                                                                                                     |         | ? P.M. 5/5/1986                                                                                                                                                                                      |  | subject ingested drugs                                                                                                                                   |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED                                                                                                                |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                                                          |  | 21f. LOCATION                                                                                                                                            |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                        |         | home                                                                                                                                                                                                 |  | 2229 Rogene Dr., Balto. City, Md.                                                                                                                        |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an                                                           |         | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion                                                                   |  |                                                                                                                                                          |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| death resulted from:                                                                                                                |         | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                          |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| ACTUAL SIGNATURE                                                                                                                    |         | TITLE (SPECIFY)                                                                                                                                                                                      |  | DATE SIGNED                                                                                                                                              |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| Gregory R. Kauffman, M.D.                                                                                                           |         | M.D. Assistant MEDICAL EXAMINER                                                                                                                                                                      |  | 5/6/86                                                                                                                                                   |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                     |         | ADDRESS                                                                                                                                                                                              |  |                                                                                                                                                          |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                           |         | 23b. DATE                                                                                                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION                                                       |  |                                     |  |                          |  |       |  |      |  |          |  |
| Removal-Burial                                                                                                                      |         | 5/9/86                                                                                                                                                                                               |  | Seese Hill                                                                                                                                               |  | Canadensis, Monroe, PA                                              |  |                                     |  |                          |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                           |         | 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                        |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| Henry W. Jenkins & Sons Co.                                                                                                         |         | MAY 8 1986                                                                                                                                                                                           |  | Julia Davidson-Randall                                                                                                                                   |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |
| 4905 York Road Balto., MD 21212                                                                                                     |         |                                                                                                                                                                                                      |  |                                                                                                                                                          |  |                                                                     |  |                                     |  |                          |  |       |  |      |  |          |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Removal of the 5' 6" section of the  
Henry W. Jackson & Son Co.,  
New York, New York, MD, 21110

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J. 1000  
R. 1000  
S. 1000  
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |               |                                                                                                                                          |                                                    |                                                                                                                                                          |                                                                    |                                                                                              |                                        |                                                                                  |  | REG. NO. 14204                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) aka FIRST William MIDDLE Charles LAST Roszel Jr.<br>Baby Boy William Charles Szulczewski                                                                                                                                                                                                                                                                                                                |               |                                                                                                                                          |                                                    |                                                                                                                                                          |                                                                    | 2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 5-22 19 86                                         |                                        | 2b. HOUR 3:15 a.m.                                                               |  |                                              |  |
| 3. SEX Male                                                                                                                                                                                                                                                                                                                                                                                                                              | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 5 20 86                                                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 2 | IF UNDER 24 HRS. HOURS MIN.                                                                                                                              | 7c. DATE PRONOUNCED DEAD 5-22 19 86                                |                                                                                              |                                        |                                                                                  |  |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland                                                                                                                                                                                                                                                                                                                                                                                       |               | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                                      |                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.                                     |                                        |                                                                                  |  |                                              |  |
| 10. CITY OR TOWN OF DEATH Baltimore                                                                                                                                                                                                                                                                                                                                                                                                      |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital |                                                    |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY None |                                                                                  |  |                                              |  |
| 13a. STATE Maryland                                                                                                                                                                                                                                                                                                                                                                                                                      |               | 13b. COUNTY A.A.                                                                                                                         |                                                    | 13c. CITY OR TOWN Pasadena                                                                                                                               |                                                                    | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                        | 13e. STREET ADDRESS 429 Maryland Ave 21122                                       |  |                                              |  |
| 14. FATHER'S NAME FIRST William MIDDLE G. LAST Roszel Sr                                                                                                                                                                                                                                                                                                                                                                                 |               |                                                                                                                                          |                                                    | 15. MOTHER'S MAIDEN NAME FIRST Lenee MIDDLE E. LAST Szulczewski                                                                                          |                                                                    |                                                                                              |                                        |                                                                                  |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No                                                                                                                                                                                                                                                                                                                                                                    |               | 16b. SOCIAL SECURITY NO. None                                                                                                            |                                                    | 17. INFORMANT Alice Szulczewski                                                                                                                          |                                                                    |                                                                                              |                                        | ADDRESS Same as 13e                                                              |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Subdural Hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Birth Trauma<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                      |               |                                                                                                                                          |                                                    |                                                                                                                                                          |                                                                    |                                                                                              |                                        |                                                                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                       |               |                                                                                                                                          |                                                    |                                                                                                                                                          |                                                                    |                                                                                              |                                        |                                                                                  |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                        |                                                    |                                                                                                                                                          |                                                                    |                                                                                              |                                        | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |               | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                     |                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                                                                    |                                                                                              |                                        |                                                                                  |  |                                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                   |               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                              |                                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                    |                                                                                              |                                        |                                                                                  |  |                                              |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |               |                                                                                                                                          |                                                    |                                                                                                                                                          |                                                                    |                                                                                              |                                        |                                                                                  |  |                                              |  |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i>                                                                                                                                                                                                                                                                                                                                                                                                  |               | TITLE (SPECIFY) Assistant M.D.                                                                                                           |                                                    |                                                                                                                                                          |                                                                    | MEDICAL EXAMINER                                                                             |                                        | DATE SIGNED 5-22-86                                                              |  |                                              |  |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                                    |               | ADDRESS 111 Penn St., Balto., Md. 21201                                                                                                  |                                                    |                                                                                                                                                          |                                                                    |                                                                                              |                                        |                                                                                  |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                                                                                                                                                         |               | 23b. DATE 5/27/86                                                                                                                        |                                                    | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park                                                                                              |                                                                    |                                                                                              |                                        | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md                      |  |                                              |  |
| 24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md                                                                                                                                                                                                                                                                                                                                                                           |               |                                                                                                                                          |                                                    |                                                                                                                                                          |                                                                    | 25a. DATE REC'D. BY REGISTRAR MAY 27 1986                                                    |                                        | 25b. REGISTRAR'S SIGNATURE <i>Jana Davidson</i>                                  |  |                                              |  |

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

RECEIVED OCTOBER 20 1964

WATERBURY



MAINTENANCE DEPARTMENT

MAY 27 1964

00-07565

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                      |         | 2a. DATE OF DEATH                                                                                      |  | 2b. HOUR                                                                                                                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Baby Boy                                                                                                                                                                                                                                                                                                                 |         | 5 17 86                                                                                                |  | 1:35 AM                                                                                                                                                  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                   | 4. RACE | 5. DATE OF BIRTH                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                                          |  |
| Male                                                                                                                                                                                                                                                                                                                     | White   | 5 17 86                                                                                                |  | 16 months YRS.                                                                                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Md.                                                                                                                                                                                                                                                                                                                      |         | U.S.                                                                                                   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                     |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                          |         | Francis S. Ray Hosp                                                                                    |  | N/A                                                                                                                                                      |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                               |         | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  |
| Md.                                                                                                                                                                                                                                                                                                                      |         | Balto.                                                                                                 |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                        |         | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16. SOCIAL SECURITY NO.                                                                                                                                  |  |
| Ray                                                                                                                                                                                                                                                                                                                      |         | Catherine R. Tracy                                                                                     |  | N/A                                                                                                                                                      |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN)                                                                                                                                                                                                                                                         |         | 17b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT ADDRESS                                                                                                                                    |  |
| 0                                                                                                                                                                                                                                                                                                                        |         | N/A                                                                                                    |  | Mother 1423 Stromeyer Way                                                                                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                |         |                                                                                                        |  |                                                                                                                                                          |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                             |         |                                                                                                        |  |                                                                                                                                                          |  |
| IMMEDIATE CAUSE (a) Severe Prematurity                                                                                                                                                                                                                                                                                   |         |                                                                                                        |  |                                                                                                                                                          |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Normal Cephalic 2 to Facial Presentation                                                                                                                                                                                                                                              |         |                                                                                                        |  |                                                                                                                                                          |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                                       |         |                                                                                                        |  |                                                                                                                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                         |         |                                                                                                        |  |                                                                                                                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  |
| N/A                                                                                                                                                                                                                                                                                                                      |         | N/A                                                                                                    |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                       |         | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED                                                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                          |         | HOUR A.M. MONTH DAY YEAR                                                                               |  | N/A                                                                                                                                                      |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                     |         | 21e. PLACE OF INJURY                                                                                   |  | 21f. LOCATION                                                                                                                                            |  |
| WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                              |         | N/A                                                                                                    |  | STREET CITY OR TOWN COUNTY STATE                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/17/86, 1986, to 5/17/86, 1986, that (I) (we) last saw the deceased alive on 5/17/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |         |                                                                                                        |  |                                                                                                                                                          |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                           |         |                                                                                                        |  | 22c. DEGREE                                                                                                                                              |  |
| F. J. V. Roy                                                                                                                                                                                                                                                                                                             |         |                                                                                                        |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                    |         |                                                                                                        |  | 22e. ADDRESS                                                                                                                                             |  |
| F. J. V. Roy                                                                                                                                                                                                                                                                                                             |         |                                                                                                        |  | 4049 Easton Ave                                                                                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                |         | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  |
| Removal                                                                                                                                                                                                                                                                                                                  |         | 5-22-86                                                                                                |  |                                                                                                                                                          |  |
| 23d. LOCATION                                                                                                                                                                                                                                                                                                            |         | 23e. COUNTY                                                                                            |  | 23f. STATE                                                                                                                                               |  |
| CITY OR TOWN                                                                                                                                                                                                                                                                                                             |         |                                                                                                        |  |                                                                                                                                                          |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                     |         |                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  |
| NAME ADDRESS                                                                                                                                                                                                                                                                                                             |         |                                                                                                        |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |  |
| Anatomy Board Balto., Md.                                                                                                                                                                                                                                                                                                |         |                                                                                                        |  | MAY 26 1986                                                                                                                                              |  |

00-05262

RECEIVED 10/10/1954

100% COTTON FIBER

WELLS





00-07942

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                |                                                                                                                                                            |                                                                              |                                                                          |                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Rose Tankard                                                                                                                                                                                                                                                                                                             |                                                                                                                                |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>May 24, 1986                           |                                                                          | 2b HOUR<br>11:35 AM                                                                                                        |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                     | 4 RACE<br>Black                                                                                                                | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 27, 1986                                                                                                         | 6 AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.         |                                                                                                                            |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                | 7b CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                                                        | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |                                                                          |                                                                                                                            |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Villa St. Michael |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired   | 12b KIND OF BUSINESS OR INDUSTRY                                         |                                                                                                                            |
| 13a STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                |                                                                                                                                                            | 13b COUNTY<br>N/A                                                            | 13c CITY OR TOWN<br>Baltimore                                            | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles R. Wilson                                                                                                                                                                                                                                                                                                                          |                                                                                                                                | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Wilson                                                                                                |                                                                              |                                                                          |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                          |                                                                                                                                | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A                                                                                              |                                                                              | 17 INFORMANT<br>ADDRESS<br>Geraldine Griner 3010 Elgin Ave 21216         |                                                                                                                            |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary Insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                                                                                                                |                                                                                                                                                            |                                                                              |                                                                          |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                              |                                                                                                                                |                                                                                                                                                            |                                                                              |                                                                          |                                                                                                                            |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                              | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                            |                                                                                                                                | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                                                          |                                                                                                                            |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                            |                                                                                                                                | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                                          |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>86</u> , to <u>May 24</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |                                                                                                                                |                                                                                                                                                            |                                                                              |                                                                          |                                                                                                                            |
| 22b SIGNATURE<br><u>Harold B. Bob</u>                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |                                                                              | 22c. DATE SIGNED<br>May 25, 1986                                         |                                                                                                                            |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harold B. Bob, M.D.                                                                                                                                                                                                                                                                                                                         |                                                                                                                                | 22e ADDRESS<br>7220 Park Heights Ave. Balto., MD                                                                                                           |                                                                              |                                                                          |                                                                                                                            |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                  | 23b DATE<br>5/27/86                                                                                                            | 23c NAME OF CEMETERY OR CREMATORY<br>Maryland Nat. Mem. Pk.                                                                                                | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel, Md.                     |                                                                          |                                                                                                                            |
| 24 FUNERAL DIRECTOR<br>NAME<br>Dyett Funeral Home Baltimore, MD 21207                                                                                                                                                                                                                                                                                                               |                                                                                                                                | 25 REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE<br>MAY 28 1986 <u>Julia Davidson-Randall</u>                                                              |                                                                              |                                                                          |                                                                                                                            |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2028 00100 8002

WINTER



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and reported.

BP\_\_\_\_\_

DHMH - 16 50M 4/83  
(VRA 15, 4)

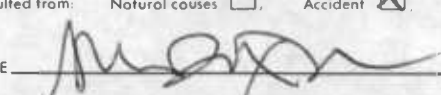
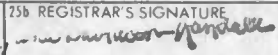
| STATE OF MARYLAND                                                                                                                                                                                                                                                                              |                                                                     |                                                                                                                                            |                                                                                                                         |                                                                                                                                                          |                                      |                                                                                              |                                |                                 |         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------|---------------------------------|---------|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                        |                                                                     |                                                                                                                                            |                                                                                                                         |                                                                                                                                                          |                                      |                                                                                              |                                |                                 |         |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                           |                                                                     |                                                                                                                                            |                                                                                                                         |                                                                                                                                                          |                                      |                                                                                              |                                |                                 |         |  |
| REG. NO. 14207                                                                                                                                                                                                                                                                                 |                                                                     |                                                                                                                                            |                                                                                                                         |                                                                                                                                                          |                                      |                                                                                              |                                |                                 |         |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                               | aka FIRST Laura                                                     | MIDDLE Helen                                                                                                                               | LAST Tarun                                                                                                              | 2a. DATE OF DEATH                                                                                                                                        | MONTH 5                              | DAY 23                                                                                       | YEAR 86                        | 2b. HOUR                        | 3:28 PM |  |
| 3. SEX                                                                                                                                                                                                                                                                                         | Female                                                              | 4. RACE                                                                                                                                    | White                                                                                                                   | 5. DATE OF BIRTH                                                                                                                                         | MONTH 10                             | DAY 31                                                                                       | YEAR 11                        | 6. AGE (IN YEARS LAST BIRTHDAY) | 74 YRS. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                      | Maryland                                                            | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                               | U.S.A.                                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | Baltimore City                                                                               | MD.                            |                                 |         |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                      | Baltimore                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     | 2640 Marbourne Ave ( Home )                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            | Housewife                            | 12b. KIND OF BUSINESS OR INDUSTRY                                                            | Home Maker                     |                                 |         |  |
| 13a. STATE                                                                                                                                                                                                                                                                                     | Maryland                                                            | 13b. COUNTY                                                                                                                                | Baltimore                                                                                                               | 13c. CITY OR TOWN                                                                                                                                        | Baltimore                            | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | 2640 Marbourne Ave              | 21230   |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                              | FIRST Edward                                                        | MIDDLE                                                                                                                                     | LAST Hoffman                                                                                                            | 15. MOTHER'S MAIDEN NAME                                                                                                                                 | FIRST Sarah                          | MIDDLE                                                                                       | LAST Miller                    |                                 |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                              | No                                                                  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                                                                                       | 220-01-1504                                                                                                             | 17. INFORMANT                                                                                                                                            | Glenn Tarun                          | ADDRESS                                                                                      | Same as 13e                    |                                 |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                          | IMMEDIATE CAUSE (a)                                                 | Obstructive Pulmonary Disease                                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                            | 10-15 yrs                                                                                                                                                |                                      |                                                                                              |                                |                                 |         |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                 | DUE TO, OR AS A CONSEQUENCE OF (b)                                  | Chronic Bronchitis                                                                                                                         | 10 yrs                                                                                                                  |                                                                                                                                                          |                                      |                                                                                              |                                |                                 |         |  |
|                                                                                                                                                                                                                                                                                                | DUE TO, OR AS A CONSEQUENCE OF (c)                                  | Cancer Larynx & Chronic tracheostomy                                                                                                       | 8 yrs                                                                                                                   |                                                                                                                                                          |                                      |                                                                                              |                                |                                 |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                               |                                                                     |                                                                                                                                            |                                                                                                                         |                                                                                                                                                          |                                      |                                                                                              |                                |                                 |         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                                          |                                      |                                                                                              |                                |                                 |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                             | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                                         |                                                                                                                                                          |                                      |                                                                                              |                                |                                 |         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                             |                                                                                                                         |                                                                                                                                                          |                                      |                                                                                              |                                |                                 |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 80 to 5-21 19 86, that (I) (we) lost saw the deceased alive on 5-21 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death. |                                                                     |                                                                                                                                            |                                                                                                                         |                                                                                                                                                          |                                      |                                                                                              |                                |                                 |         |  |
| 23a. SIGNATURE                                                                                                                                                                                                                                                                                 | DEGREE                                                              | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 23c. DATE SIGNED                                                                                                        | 5/25/86                                                                                                                                                  |                                      |                                                                                              |                                |                                 |         |  |
| 23d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                          | GLEN E JOHNSON MD                                                   | 23e. ADDRESS SUITE 202 PINE HEIGHTS MED CENTER 1001 PINE HEIGHTS AVE. BALF. MD 21229                                                       |                                                                                                                         |                                                                                                                                                          |                                      |                                                                                              |                                |                                 |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                      | Burial                                                              | 23b. DATE                                                                                                                                  | 5/27/86                                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       | Meadowridge Mem Park                 | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                      | Baltimore Howard Md            |                                 |         |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                           | George J. Gonce                                                     | ADDRESS                                                                                                                                    | 4001 Ritchie Hwy Balto Md                                                                                               | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            | MAY 27 1986                          | 25b. REGISTRAR'S SIGNATURE                                                                   |                                |                                 |         |  |



00-07757

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| #22a, Film G617 7/18/86 kam STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                          |  |                         |                                                                                                                                       |                                                                           |  |                                                                                                                                                             |                                                                                                            |                                                                           |                                                               | REG. NO. 14208                                                                                                      |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR<br>1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CHRISTOPHER CHARLES TAYLOR</b>                                                                                                                                                                                                                                                                                                                                                             |  |                         |                                                                                                                                       |                                                                           |  |                                                                                                                                                             | 2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>5 21 1986</b> |                                                                           | 2b. HOUR<br><b>4P</b>                                         |                                                                                                                     |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>WHITE</b> |                                                                                                                                       | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>OCT. 14, 1972</b>                   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>13</b>                                                                                                           |                                                                                                            | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>5 21 1986</b>               |                                                               | 2d. HOUR<br><b>4P</b>                                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                            |                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                            |                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> |                                                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |                                                                           |  |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>STUDENT</b>                            |                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SCHOOL</b>            |                                                                                                                     |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                         |                                                                                                                                       |                                                                           |  | 13b. COUNTY<br><b>A A CO.</b>                                                                                                                               |                                                                                                            | 13c. CITY OR TOWN<br><b>SEVERNA PARK</b>                                  |                                                               | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>CHARLES MILLARD TAYLOR</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                         |                                                                                                                                       |                                                                           |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>BARBARA PORTER</b>                                                                                         |                                                                                                            |                                                                           |                                                               |                                                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                         |                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                                    |  | 17. INFORMANT (Mother) ADDRESS<br><b>Mrs. Barbara Annibal Thornton, Col. 4326 East 119th Way</b>                                                            |                                                                                                            |                                                                           |                                                               |                                                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pellet wound of head (air gun)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost                                                                                                                      |  |                         |                                                                                                                                       |                                                                           |  |                                                                                                                                                             |                                                                                                            |                                                                           |                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                                          |  |                         |                                                                                                                                       |                                                                           |  |                                                                                                                                                             |                                                                                                            |                                                                           |                                                               |                                                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                         |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                         |  |                                                                                                                                                             |                                                                                                            |                                                                           |                                                               | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                               |  |                         |                                                                                                                                       | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR<br><b>4:15 M. 5-19- 1986</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Air gun discharged.</b>                                                 |                                                                                                            |                                                                           |                                                               |                                                                                                                     |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                            |  |                         |                                                                                                                                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>302 Pertch Rd., Pasadena, Anne Arundel MD</b>                                                          |                                                                                                            |                                                                           |                                                               |                                                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . <del>Undetermined manner</del> <input checked="" type="checkbox"/> . |  |                         |                                                                                                                                       |                                                                           |  |                                                                                                                                                             |                                                                                                            |                                                                           |                                                               |                                                                                                                     |  |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                                      |  |                         |                                                                                                                                       | TITLE (SPECIFY)<br>M.D. <b>Assistant</b>                                  |  |                                                                                                                                                             |                                                                                                            | DATE SIGNED<br><b>5-23-86</b>                                             |                                                               |                                                                                                                     |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         |                                                                                                                                       | ADDRESS<br><b>111 Penn St., Balto., MD 21201</b>                          |  |                                                                                                                                                             |                                                                                                            |                                                                           |                                                               |                                                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                         |                                                                                                                                       | 23b. DATE<br><b>MAY 27, 1986</b>                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GLEN HAVEN MEM. PARK</b>                                                                                           |                                                                                                            | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>GLEN BURNIE A A CO. MD.</b> |                                                               |                                                                                                                     |  |
| 24. FUNERAL DIRECTOR NAME<br><b>SINGLETON FUNERAL HOME</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                         |                                                                                                                                       |                                                                           |  | ADDRESS<br><b>GLEN BURNIE, MARYLAND</b>                                                                                                                     |                                                                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 27 1986</b>                       |                                                               | 25b. REGISTRAR'S SIGNATURE<br> |  |

07/84  
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(VR A15 ME (5))

100% COTTON

100% COTTON

100% COTTON



100% COTTON



0-07568

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14209

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                  |                                                       |                                                                                                                                      |                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Daniel Taylor</i>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>5-23-86</i> |                                                                                                                                      | 2b. HOUR<br>M<br><i></i> |  |
| 3. SEX<br><i>male</i>                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><i>Col.</i>                                                           |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3 10 10</i>                                                                                 |                          |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>76</i> YRS                                                                                                                                                                                                                                                                                                                                                                                            |  | 7. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>V.A.</i>                       |                                                       | 8. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                         |                          |  |
| 9. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>V.A.</i>                                                                                                                                                                                                                                                                                                                                                                                  |  | 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                    |                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>2221 Callow Ave.</i> |                          |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12b. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                               |  | 13a. CITY OR TOWN<br><i>BALTO</i>                                                |                                                       | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                      |                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Henry Taylor</i>                                                                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>SALLIE SAIN</i>              |                                                       | 16. SOCIAL SECURITY NO.<br><i>217 012688</i>                                                                                         |                          |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>                                                                                                                                                                                                                                                                                                                                                           |  | 17b. SOCIAL SECURITY NO.<br><i>217 012688</i>                                    |                                                       | 17c. INFORMANT<br>ADDRESS<br><i>Mrs. Dorothy Taylor 2221 Callow Ave. 21217</i>                                                       |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>BRAIN ANOXIA</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>CARDIO RESPIRATORY ARREST</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Renal Failure - Myeloma Kidney</i><br>Approximate interval between onset and death: <i>2 years</i>                                                                      |  |                                                                                  |                                                       |                                                                                                                                      |                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><i>Multiple Myeloma, Severe Aortic Insufficiency, Congestive Heart Failure, Coronary Artery Disease</i>                                                                                                                                                                                                 |  |                                                                                  |                                                       |                                                                                                                                      |                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                 |                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                            |                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                       |                          |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)               |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                    |                          |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>July 8</i> , 19 <i>83</i> , to <i>MAY 23</i> , 19 <i>86</i> , that I (we) last saw the deceased alive on <i>5/29</i> , 19 <i>86</i> , and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |                                                                                  |                                                       |                                                                                                                                      |                          |  |
| 22b. SIGNATURE<br><i>Andrew G. Gordon</i>                                                                                                                                                                                                                                                                                                                                                                                                   |  | DEGREE<br><i>M.D.</i>                                                            |                                                       | 22c. DATE SIGNED<br><i>5/23/86</i>                                                                                                   |                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>ANDREW G. GORDON</i>                                                                                                                                                                                                                                                                                                                                                                            |  | 22e. ADDRESS<br><i>ST Agnes Hospital 900 CATON Ave Belt 21229</i>                |                                                       |                                                                                                                                      |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><i>5/29/86</i>                                                      |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mount Olivet Cem. W. side</i>                                                               |                          |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>North Thompson Co VA</i>                                                                                                                                                                                                                                                                                                                                                                   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Joseph L. Russ 2222 W. North Ave.</i> |                                                       |                                                                                                                                      |                          |  |
| 25a. DATE REC'D BY REGISTRAR<br><i>MAY 20 1986</i>                                                                                                                                                                                                                                                                                                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><i></i>                                            |                                                       |                                                                                                                                      |                          |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.)



*[Faint, illegible handwritten text covering the page]*



00-08973

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                           |  |                      |                                                                                                                                   |                                                             |                                                       |                                                                                                                                                          |                                                                          |                                                                   |                                                                           | REG. NO. 14210                                                                                                      |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>John C. Taylor</b>                                                                                                                                                                                                                                                                                                                                                            |  |                      |                                                                                                                                   |                                                             |                                                       |                                                                                                                                                          |                                                                          |                                                                   |                                                                           | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> <b>XX 5-23 19 86</b> |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE <b>Black</b> |                                                                                                                                   | 5. DATE OF BIRTH <b>July 28, 1900 85</b>                    |                                                       | 6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.                                                                                                           |                                                                          | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.                        |                                                                           | 2c. DATE PRONOUNCED DEAD <b>5-24 19 86</b>                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>                                                                                                                                                                                                                                                                                                                                                             |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                        |                                                             |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                          |                                                                   | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Baltimore City, MD.</b> |                                                                                                                     |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3505 Berwyn Avenue</b> |                                                             |                                                       |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>---</b> |                                                                   |                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY <b>0</b>                                                                          |  |
| 13a. STATE <b>Md</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                      | 13b. COUNTY <b>None</b>                                                                                                           |                                                             | 13c. CITY OR TOWN <b>Baltimore</b>                    |                                                                                                                                                          | 13d. INSIDE CITY LIMITS? <b>YES XX NO <input type="checkbox"/></b>       |                                                                   | 13e. STREET ADDRESS <b>3505 Berwyn Ave. 21207</b>                         |                                                                                                                     |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <b>John D Taylor</b>                                                                                                                                                                                                                                                                                                                                                        |  |                      |                                                                                                                                   |                                                             |                                                       | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Margaret Evans</b>                                                                                       |                                                                          |                                                                   |                                                                           |                                                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>---</b>                                                                                                                                                                                                                                                                                                                                     |  |                      |                                                                                                                                   | 16b. SOCIAL SECURITY NO. <b>219-58-5225T</b>                |                                                       | 17. INFORMANT ADDRESS <b>Margaret Sawyer, 3505 Berwyn Ave. 21207</b>                                                                                     |                                                                          |                                                                   |                                                                           |                                                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b>---</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>---</b>                                          |  |                      |                                                                                                                                   |                                                             |                                                       |                                                                                                                                                          |                                                                          |                                                                   |                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                |  |                      |                                                                                                                                   |                                                             |                                                       |                                                                                                                                                          |                                                                          |                                                                   |                                                                           |                                                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                            |  |                      |                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                                                       |                                                                                                                                                          |                                                                          |                                                                   |                                                                           | 20. AUTOPSY? <b>YES <input type="checkbox"/> NO XX</b>                                                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                               |  |                      |                                                                                                                                   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                                                                          |                                                                   |                                                                           |                                                                                                                     |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                            |  |                      |                                                                                                                                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                                                       | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                          |                                                                   |                                                                           |                                                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <b>Natural causes XX</b> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |                                                                                                                                   |                                                             |                                                       |                                                                                                                                                          |                                                                          |                                                                   |                                                                           |                                                                                                                     |  |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i>                                                                                                                                                                                                                                                                                                                                                                           |  |                      |                                                                                                                                   | TITLE (SPECIFY) <b>Assistant</b>                            |                                                       |                                                                                                                                                          |                                                                          | MEDICAL EXAMINER                                                  |                                                                           |                                                                                                                     |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>                                                                                                                                                                                                                                                                                                                                                      |  |                      |                                                                                                                                   | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>              |                                                       |                                                                                                                                                          |                                                                          |                                                                   |                                                                           |                                                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                           |  |                      | 23b. DATE <b>5/31/86</b>                                                                                                          |                                                             | 23c. NAME OF CEMETERY OR CREMATORY <b>Mile Branch</b> |                                                                                                                                                          |                                                                          | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fayetteville, N.C.</b> |                                                                           |                                                                                                                     |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS <b>Law Funeral Home 4611 Park Heights Ave. 21215</b>                                                                                                                                                                                                                                                                                                                            |  |                      |                                                                                                                                   |                                                             |                                                       | 25a. DATE RECD BY POSTAL MAIL <b>MAY 29 1986</b>                                                                                                         |                                                                          | 25b. REGISTERED MAIL <i>John Anderson</i>                         |                                                                           |                                                                                                                     |  |

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

FOR COTTON & BEE

UNDER

WIND



Handwritten text at the bottom left corner, possibly a signature or date.

00-06102

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8614211

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                          |  |                                                                                                                                                          |  |                                                                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                |  | 1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> Mary <sup>MIDDLE</sup> B. <sup>LAST</sup> Taylor                       |  | 2a. DATE OF DEATH MONTH DAY YEAR 05 08 86                                                                                                                |  | 2b. HOUR 320 AM                                                                                                                    |  |
| 3. SEX Female                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE Caucasian                                                                                                        |  | 5. DATE OF BIRTH MONTH DAY YEAR 9-10-1911                                                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS                                                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY? USA                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.                                                                            |  |
| 10. CITY OR TOWN OF DEATH BALTO CITY                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk                                                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.                                                                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Baltimore 13c. CITY OR TOWN Balto.                                                                                                                                                                                                             |  |                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS / ZIP CODE 1208 Edmondson Avenue 21228                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Walsh                                                                                                                                                                                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hanna Carroll                                                                 |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO                                                                                     |  |                                                                                                                                    |  |
| 16b. SOCIAL SECURITY NO 577-50-7096                                                                                                                                                                                                                                                                                                                                   |  | 17. INFORMANT ADDRESS 21228 Bartgis Taylor 1208 Edmondson Ave                                                            |  |                                                                                                                                                          |  |                                                                                                                                    |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PULMONARY CONGESTION AND EDEMA<br>DUE TO, OR AS A CONSEQUENCE OF, (b) ALCOHOLIC LIVER DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF, (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                          |  |                                                                                                                                                          |  |                                                                                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a                                                                                                                                                                                                                                  |  |                                                                                                                          |  |                                                                                                                                                          |  |                                                                                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                         |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                                                                           |  |                                                                                                                                    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                       |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                    |  |
| 22a. I certify that (this hospital) attended the deceased from MAY 7 19 86, to May 8 19 86, that (we) last saw the deceased alive on May 8 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                            |  |                                                                                                                          |  |                                                                                                                                                          |  |                                                                                                                                    |  |
| 22b. SIGNATURE Bert F. Morton                                                                                                                                                                                                                                                                                                                                         |  | DEGREE M.D.                                                                                                              |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED                                                                                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERT F. MORTON                                                                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS                                                                                                             |  |                                                                                                                                                          |  |                                                                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE 05-09-86                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY Security Precress                                                                                                     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto. MD                                                                     |  |
| 24. FUNERAL DIRECTOR NAME CREMATION SOCIETY OF MD, BALTIMORE, MD ADDRESS 21228                                                                                                                                                                                                                                                                                        |  |                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR MAY 9 1986                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall                                                                                  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-08103

WINTER

WINTER



NOTICE

0-08128

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                |  | 6 6 1 4 2 1 2                                                                                                                         |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |  |                                                    |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Mozelle W. Taylor</i>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>5-28-86</i>                                                                                                       |  | 2b. HOUR<br><i>11:00 p.m.</i>                                                                                              |  |                                                    |  |
| 3. SEX<br><i>F</i>                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><i>Black</i>                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>9 28 25</i>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>60</i> YRS                                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balto. Md.</i>                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>City</i> MD.                                                                    |  |                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lutheran Hospital</i> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>LAB-AIDE</i>                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>J.H.H.</i> |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                     |  |                                                                                                                                       |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13b. STREET ADDRESS / ZIP CODE<br><i>630 Wildwood Parkway 21229</i>                                                        |  |                                                    |  |
| 13a. STATE<br><i>Md</i>                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY                                                                                                                           |  | 13c. CITY OR TOWN<br><i>Baltimore</i>                                                                                                                       |  |                                                                                                                            |  |                                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>ELMER Williams</i>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Ophelia</i>                                                                                             |  |                                                                                                                            |  |                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><i>219-10-6493</i>                                                                                        |  | 17. INFORMANT<br><i>Moses Taylor</i>                                                                                                                        |  | ADDRESS<br><i>630 Wildwood Parkway</i>                                                                                     |  |                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Ca. of pancreas.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>a</i>                                                                                                                                                                                                                                   |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                            |  |                                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-28</i> , 19 <i>86</i> , to <i>5-28</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>5-28</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.          |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |  |                                                    |  |
| 22b. SIGNATURE<br><i>Matthew</i>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><i>5-28-86</i>                                                                                         |  |                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>A. Matthew</i>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |  | 22e. ADDRESS<br><i>Lutheran Hospital 730 Ashburton St. Baltimore.</i>                                                                                       |  |                                                                                                                            |  |                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><i>6-2-86</i>                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>King Memorial Park</i>                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Md.</i>                                                         |  |                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>James A. Morton + Sons</i>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                       |  | ADDRESS<br><i>1701 Laurens Street</i>                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 2 1986</i>                                                                         |  |                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Burdett</i>                                                                                                          |  |                                                                                                                            |  |                                                    |  |

W. E. B. DUBOIS

W. E. B. DUBOIS

20%



8



00-06

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED NON MED DR M. KORELL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

William Taylor

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                                      |                                                                                                 |                                                                                                                                       |                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WILLIAM Louis TAYLOR                                                                                                                                                                                                                                                                               |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 5, 1986                     |                                                                                                                                                             | 2b. HOUR<br>1:14P M                                                                                                                        |                                                                                      |                                                                                                 |                                                                                                                                       |                                                                     |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br>Black                                                                                                                        |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 9 14                                                                                                                |                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS                                            |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                                    |                                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |                                                                                                 |                                                                                                                                       |                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |                                                                        |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A                                                                    |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Railroad                                                   |                                                                                                                                       |                                                                     |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                         | 13b. COUNTY                                                            |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                                                                                                             |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                       | 13e. STREET ADDRESS / ZIP CODE<br>633 Aisquith Street Apt. 4J 21202 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ouellie Taylor                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>-                     |                                                                                                                                                             |                                                                                                                                            | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) YES             |                                                                                                 |                                                                                                                                       |                                                                     |  |
| 16b. SOCIAL SECURITY NO.<br>110-07-8831                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         | 17. INFORMANT<br>Mary Harris 1930 East 31st Street                     |                                                                                                                                                             |                                                                                                                                            |                                                                                      |                                                                                                 | ADDRESS                                                                                                                               |                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myelogenous Leukemia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 months                                                                              |                                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                             |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                                      |                                                                                                 |                                                                                                                                       |                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                            | 20a. AUTO*SY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |                                                                                      |                                                                                                 |                                                                                                                                       |                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                   |  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                      |                                                                                                 |                                                                                                                                       |                                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/25</u> , 19 <u>86</u> , to <u>5/5</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/4</u> , 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                                      |                                                                                                 |                                                                                                                                       |                                                                     |  |
| 22b. SIGNATURE<br><u>Valter N. Hernan</u>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         | DEGREE<br>MD                                                           |                                                                                                                                                             | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                      | 22c. DATE SIGNED<br>5/5/86                                                                      |                                                                                                                                       |                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Valter N. Hernan                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         | 22e. ADDRESS<br>Johns Hopkins Hospital                                 |                                                                                                                                                             |                                                                                                                                            |                                                                                      |                                                                                                 |                                                                                                                                       |                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br>BURIAL                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br>5/10/86                                                                                                                    |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery                                                                                                    |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                         |                                                                                                 |                                                                                                                                       |                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>March Funeral Homes 1101 East North Avenue                                                                                                                                                                                                                                                                             |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>MAY 9 1986                                                                                                |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>                                     |                                                                                                                                       |                                                                     |  |

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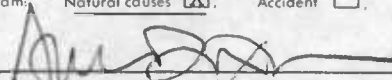
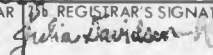


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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                |  |                         |  |                                                                                                                                       |  |                                                                                                                     |  |                                                                                                                                                             |  | REG. NO. 4 2 1 4                                                                                            |  |                                                                                     |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>AGNES Anastasis TEEPLE</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                         |  |                                                                                                                                       |  |                                                                                                                     |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>5 1 19 86</b> |  | 7b. HOUR<br>M<br><b>2:30 P</b>                                                      |  |
| 1. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 28, 1889 96</b>                                                                         |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>96</b>                                                                |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                    |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>5 3 19 86</b>                                              |  | 7d. HOUR<br>P M<br><b>2:30 P</b>                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                         |  |                                                                                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                               |  |                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>301 McMechen St.</b> |  |                                                                                                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerical</b>                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Civil Eng.</b>                                                      |  |                                                                                     |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                         |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                       |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br><b>301 McMechen Street</b>                                                           |  |                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Laurence Lashoska</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                         |  |                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Elizabeth ?</b>                                            |  |                                                                                                                                                             |  |                                                                                                             |  |                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>214-40-1563</b>                                                                                        |  | 17. INFORMANT<br>ADDRESS<br><b>Self - 1981</b>                                                                      |  |                                                                                                                                                             |  |                                                                                                             |  |                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                          |  |                         |  |                                                                                                                                       |  |                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                    |  |                         |  |                                                                                                                                       |  |                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                             |  |                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                     |  |                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                             |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                    |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  |                                                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)                                                                               |  |                                                                                                             |  |                                                                                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                            |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                           |  |                                                                                                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                             |  |                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |                                                                                                                                       |  |                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                             |  |                                                                                     |  |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                |  |                         |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER                                                                             |  |                                                                                                                     |  | DATE SIGNED <b>5-4-86</b>                                                                                                                                   |  |                                                                                                             |  |                                                                                     |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                         |  | ADDRESS<br><b>111 Penn St., Balto., MD 21201</b>                                                                                      |  |                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                             |  |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                         |  | 23b. DATE<br><b>5/7/86</b>                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer Cem.</b>                                                |  |                                                                                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>                                           |  |                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>STEWART &amp; MOWEN CO., 108 W. North Ave. Balto. MD</b>                                                                                                                                                                                                                                                                                                                                                    |  |                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 6 1986</b>                                                                                    |  | 25b. REGISTRAR'S SIGNATURE<br> |  |                                                                                                                                                             |  |                                                                                                             |  |                                                                                     |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
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| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>David E. Tenney                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5-27-86                  |                                                                                                 | 2b. HOUR<br>9:55 AM |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br>Cauc                                                                                                                                                                                                                                                                                   |                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 17 24                                                   |                     |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>West Virginia                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                               |                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.                                                      |                     |  |
| 11. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital                                                                                                                                                     |                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                     |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Loader                                                                                                                                                                                                                                                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Trucking                                                                                                                                                                                                                                                     |                                                                 | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                     |  |
| 13b. CITY OR TOWN<br>N. Linthicum                                                                                                                                                                                                                                                                                                                                             |  | 13c. STREET ADDRESS / ZIP CODE<br>66 Old Annapolis Road 21090                                                                                                                                                                                                                                     |                                                                 | 13d. STREET ADDRESS / ZIP CODE                                                                  |                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Odis Earl Tenney                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary M. Chipps |                                                                                                 |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>300-22-7884                                                                                                                                                                                                                                                           |                                                                 | 17. INFORMANT<br>ADDRESS<br>David W. Tenney Same as 13c                                         |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Cardiopulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary edema<br>DUE TO, OR AS A CONSEQUENCE OF (c) Possible pneumonia/sepsis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                                                                                                                                                                                   |                                                                 |                                                                                                 |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                   |                                                                 |                                                                                                 |                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                  |                                                                 | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                     |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                    |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                          |                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                      |                     |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                                                |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                      |                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |                     |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                             |  | 22a. I certify that (I) (this hospital) attended the deceased from 5-25-86 to 5-27-86, that (I) (we) last saw the deceased alive on 5-27-86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |                                                                 | 22b. SIGNATURE<br>Dr. M. J. J. Dr. M. J. J.                                                     |                     |  |
| 22c. DATE SIGNED<br>5-27-86                                                                                                                                                                                                                                                                                                                                                   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. M. J. J.                                                                                                                                                                                                                                             |                                                                 | 22e. ADDRESS<br>3001 S. Harpers St Balto MD 21207                                               |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br>5/28/86                                                                                                                                                                                                                                                                              |                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem Park                                         |                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Balto Md                                                                                                                                                                                                                                                                                                            |  | 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce                                                                                                                                                                                                                                                   |                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>06-2-86                                                        |                     |  |
| 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                    |  | 25c. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                        |                                                                 | 25d. REGISTRAR'S SIGNATURE                                                                      |                     |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. MAYNARD ST., BALTIMORE, MD 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies of pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, a medical examiner should be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                            |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                    |  |                                                                                                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                          |  | 86                                                                                                                                     |  | 14216                                                                                                                                                       |  | REG. NO.                                                                                           |  |                                                                                                                                          |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Quintella R. Thaxton</b>                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |  | 2a. DATE OF DEATH<br><b>5-10-86</b>                                                                                                                         |  | 2b. HOUR<br><b>20:15 M</b>                                                                         |  |                                                                                                                                          |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>Black</b>                                                                                                                |  | 5. DATE OF BIRTH<br><b>4/14/86</b>                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>26 days</b>                                                  |  | 7. IF UNDER 1 YEAR<br><b>26</b>                                                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Balt. MD</b>                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>                                   |  |                                                                                                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balt.</b>                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MD.</b>                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>Balt.</b>                                                                                                            |  | 13c. CITY OR TOWN<br><b>Balt.</b>                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b>                                                             |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2010 E. Hoffman St. 21213</b>                                                                       |  |
| 14. FATHER'S NAME<br><b>JOHN THAXTON</b>                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br><b>Thelma KENNY</b>                                                                                        |  |                                                                                                                                                             |  |                                                                                                    |  |                                                                                                                                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><b>NO</b>                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                                                                                                 |  | 17. INFORMANT ADDRESS<br><b>BARBARA SMITH 2010 E. HOFFMAN ST.</b>                                                                                           |  |                                                                                                    |  |                                                                                                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Seizure Disorder, Hypothermia, Dehydration</b><br>(c) <b>Hydranencephally</b> |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                             |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                    |  |                                                                                                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY - YEAR<br><b>P.M. 19</b>                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                    |  |                                                                                                                                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION<br>STREET<br><b>CITY OR TOWN</b><br><b>COUNTY</b><br><b>STATE</b>                                                                             |  |                                                                                                    |  |                                                                                                                                          |  |
| 22a. I certify that (I, (this hospital) attended the deceased from <b>5-5-86</b> to <b>5-10-86</b> , that (I) (we) last saw the deceased alive on <b>5-10-86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)                    |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                    |  |                                                                                                                                          |  |
| 22b. SIGNATURE<br><b>Paul T. Wielebinski MD</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |  | DEGREE<br><b>MD</b>                                                                                                                                         |  |                                                                                                    |  | 22c. DATE SIGNED<br><b>5-10-86</b>                                                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul T. Wielebinski, M.D.</b>                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  | 22e. ADDRESS<br><b>4811 Lindsay Rd. Apt. #1-B Baltimore, MD</b>                                                                                             |  |                                                                                                    |  |                                                                                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>5-24-86</b>                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL</b>                                                                                                     |  | 23d. LOCATION<br>CITY OR TOWN<br><b>ANNE ARUNDEL</b>                                               |  | STATE<br><b>MARYLAND</b>                                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WM. C. MARCH F/H INC.</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                        |  | ADDRESS<br><b>1101 E. NORTH AVE.</b>                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 13 1986</b>                                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                         |  |



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00-06318

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8614217  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                          |                                                                                |                                                                                                 |                                                                                                                            |                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Hilda D. Thomas                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 11, 1986                    |                                                                                                                                                             |                                                                          | 2b. HOUR<br>M                                                                  |                                                                                                 |                                                                                                                            |                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>Black                                                                                                                     |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 12 09                                                                                                               |                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                     |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                        |                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                    |                                                                                                 |                                                                                                                            |                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1628 EAST OLIVER STREET |                                                                        |                                                                                                                                                             |                                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>DOMESTIC                                                                              |                                                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      | 13b. COUNTY                                                            |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                                           |                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br>1628 E. Oliver St. 21213 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Arthur Williams                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Hattie Henson                                                                                              |                                                                          |                                                                                |                                                                                                 |                                                                                                                            |                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-24-4871 |                                                                                                                                                             | 17. INFORMANT ADDRESS<br>Apt. 2D<br>Burnetta Hardy 5777 Hazelwood Circle |                                                                                |                                                                                                 |                                                                                                                            |                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MYOCARDIAL INFARCTION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>SUDDEN</u><br><u>SUDDEN</u> |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                          |                                                                                |                                                                                                 |                                                                                                                            |                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><u>BONE MARROW DEPRESSION DUE TO ACUTE MYELOFIBROSIS</u>                                                                                                                                                                                                                         |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                          |                                                                                |                                                                                                 |                                                                                                                            |                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                             |  |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                                 |                                                                                                                            |                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                 |                                                                                                                            |                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/29</u> 19 <u>86</u> to <u>5/11</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>5/11/86</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.                                                                   |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                          |                                                                                |                                                                                                 |                                                                                                                            |                                                            |  |
| 22b. SIGNATURE<br><u>Irvin B. Kaplan MD</u>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      |                                                                        | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                          |                                                                                |                                                                                                 | 22c. DATE SIGNED<br><u>5/13/86</u>                                                                                         |                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>IRVIN B. KAPLAN MD</u>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |                                                                        | 22e. ADDRESS<br><u>124 S Broadway 21231</u>                                                                                                                 |                                                                          |                                                                                |                                                                                                 |                                                                                                                            |                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      | 23b. DATE<br>5/16/86                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Pk.               |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus, Md.                                      |                                                                                                                            |                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>March Funeral Homes 1101 E North Ave.                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                      |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>MAY 13 1986                             |                                                                                |                                                                                                 |                                                                                                                            |                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |                                                                        |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><u>John L. ...</u>                         |                                                                                |                                                                                                 |                                                                                                                            |                                                            |  |

BP



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00-05904

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8614218  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                                     |                                                          |                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                         |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                                                 |                                                            |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                               |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                                                 |                                                            |
| Lee Andrew Thomas                                                                                                                                                                                                                                                                                                              |                                                                                                        | May 5, 1986                                                                                                                                              |                                                                     | 8:00 P M                                                 |                                                            |
| 3. SEX                                                                                                                                                                                                                                                                                                                         | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         |                                                                     | 6. AGE                                                   |                                                            |
| M                                                                                                                                                                                                                                                                                                                              | B                                                                                                      | 6/1/28                                                                                                                                                   |                                                                     | 57 YRS                                                   |                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |                                                            |
| Denville, VA                                                                                                                                                                                                                                                                                                                   | U.S.A.                                                                                                 |                                                                                                                                                          |                                                                     | BALTIMORE CITY, MD.                                      |                                                            |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                                          | 12b. KIND OF BUSINESS OR INDUSTRY                          |
| BALTIMORE                                                                                                                                                                                                                                                                                                                      | Deaton Hospital & Medical Center                                                                       |                                                                                                                                                          | LABORER                                                             |                                                          |                                                            |
| 13a. STATE                                                                                                                                                                                                                                                                                                                     | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS?                                            |                                                          |                                                            |
| Maryland                                                                                                                                                                                                                                                                                                                       |                                                                                                        | Baltimore                                                                                                                                                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                          |                                                            |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                              | 15. MOTHER'S MAIDEN NAME                                                                               |                                                                                                                                                          | 13e. STREET ADDRESS / ZIP CODE                                      |                                                          |                                                            |
|                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          | 2431 Madison Avenue 21217                                           |                                                          |                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                                                                                                                                                   | 16b. SOCIAL SECURITY NO.                                                                               | 17. INFORMANT ADDRESS                                                                                                                                    |                                                                     |                                                          |                                                            |
| NO                                                                                                                                                                                                                                                                                                                             | 230-32-6071                                                                                            | Grace Thomas 2554 Druid Hill Avenue                                                                                                                      |                                                                     |                                                          |                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |                                                                     |                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic penile carcinoma</u>                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                     |                                                          | <u>1 yr.</u>                                               |
| (c) <u></u>                                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                                     |                                                          |                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                                     |                                                          |                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                         |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                     | 20a. AUTOPSY?                                            |                                                            |
|                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                                     | YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                             |                                                                                                        | 21b. TIME OF INJURY                                                                                                                                      |                                                                     | 21c. HOW INJURY OCCURRED                                 |                                                            |
|                                                                                                                                                                                                                                                                                                                                |                                                                                                        | HOUR A.M. MONTH DAY YEAR                                                                                                                                 |                                                                     | (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)   |                                                            |
|                                                                                                                                                                                                                                                                                                                                |                                                                                                        | P.M. 19                                                                                                                                                  |                                                                     |                                                          |                                                            |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                           |                                                                                                        | 21e. PLACE OF INJURY                                                                                                                                     |                                                                     | 21f. LOCATION                                            |                                                            |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                            |                                                                                                        | (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)                                                                                                           |                                                                     | STREET CITY OR TOWN COUNTY STATE                         |                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/3/86</u> to <u>5/5/86</u> that (I) (we) last saw the deceased alive on <u>5/3</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                                     |                                                          |                                                            |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                                     | 22c. DATE SIGNED                                         |                                                            |
| Kevin Ferente MD                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |                                                                     | 5/5/86                                                   |                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                     | 22e. ADDRESS                                             |                                                            |
| KEVIN FERENTE                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                                     | 1205-6 Green Belts MD 21001                              |                                                            |
| 23a. BURIAL, CREMATION, REMOVAL                                                                                                                                                                                                                                                                                                |                                                                                                        | 23b. DATE                                                                                                                                                |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY                       |                                                            |
| BURIAL                                                                                                                                                                                                                                                                                                                         |                                                                                                        | 5/8/86                                                                                                                                                   |                                                                     | Mount Zion Cemetery                                      |                                                            |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                           |                                                                                                        | 23d. LOCATION                                                                                                                                            |                                                                     | 23e. COUNTY                                              |                                                            |
| NAME                                                                                                                                                                                                                                                                                                                           |                                                                                                        | CITY OR TOWN                                                                                                                                             |                                                                     | STATE                                                    |                                                            |
| March Funeral Homes 1101 E North Avenue                                                                                                                                                                                                                                                                                        |                                                                                                        | Lansdowne, Md.                                                                                                                                           |                                                                     |                                                          |                                                            |
| 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                                  |                                                                                                        | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |                                                                     |                                                          |                                                            |
| MAY 7 1986                                                                                                                                                                                                                                                                                                                     |                                                                                                        | Gina Davidson-Hendall                                                                                                                                    |                                                                     |                                                          |                                                            |

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JOE COLUMBIER

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                |  |                         |                                                                                                                                                |                                                                                    |                                       |                                                                                                                                               |                                                                                                 |                                                           |                                                                        | REG. NO. 14219                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>EUGENE THOMPSON</b>                                                                                                                                                                                                                                                                                                                                                        |  |                         |                                                                                                                                                |                                                                                    |                                       |                                                                                                                                               |                                                                                                 |                                                           |                                                                        | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>5-18-86</b> |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>Black</b> |                                                                                                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11/12/54</b>                              |                                       | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>31</b>                                                                                          |                                                                                                 | IF UNDER 1 YR. MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |                                                                        | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>5-18-86</b>                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     |                                                                                    |                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 |                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>          |                                                                                                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |                                                                                    |                                       |                                                                                                                                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |                                                           |                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY                                                                         |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                         | 13b. COUNTY                                                                                                                                    |                                                                                    | 13c. CITY OR TOWN<br><b>Baltimore</b> |                                                                                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                           | 13e. STREET ADDRESS<br><b>217 E. Lafayette Ave. 21217</b>              |                                                                                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sam P Fence</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                         |                                                                                                                                                |                                                                                    |                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Mae Thompson</b>                                                                     |                                                                                                 |                                                           |                                                                        |                                                                                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br><b>No</b>                                                                                                                                                                                                                                                                                                                            |  |                         |                                                                                                                                                | 16b. SOCIAL SECURITY NO.                                                           |                                       | 17. INFORMANT ADDRESS<br><b>Curtis Thompson 906 E. Preston Ave. (02)</b>                                                                      |                                                                                                 |                                                           |                                                                        |                                                                                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Narcotism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                       |  |                         |                                                                                                                                                |                                                                                    |                                       |                                                                                                                                               |                                                                                                 |                                                           |                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                     |  |                         |                                                                                                                                                |                                                                                    |                                       |                                                                                                                                               |                                                                                                 |                                                           |                                                                        |                                                                                                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                  |                                       |                                                                                                                                               |                                                                                                 |                                                           |                                                                        | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                         |  |                         |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5 P.M. 5-18-86</b>           |                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject requested drugs</b>                               |                                                                                                 |                                                           |                                                                        |                                                                                                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                         |  |                         |                                                                                                                                                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>ON the steps</b> |                                       | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1118 St Paul St Baltimore City Md</b>                                                 |                                                                                                 |                                                           |                                                                        |                                                                                                           |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |  |                         |                                                                                                                                                |                                                                                    |                                       |                                                                                                                                               |                                                                                                 |                                                           |                                                                        |                                                                                                           |  |
| ACTUAL SIGNATURE<br><b>Margie McNeil</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                         |                                                                                                                                                | TITLE (SPECIFY)<br><b>Assistant</b>                                                |                                       |                                                                                                                                               |                                                                                                 | DATE SIGNED<br><b>5-19-86</b>                             |                                                                        |                                                                                                           |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                         |                                                                                                                                                | ADDRESS<br><b>111 Penn Street</b>                                                  |                                       |                                                                                                                                               |                                                                                                 |                                                           |                                                                        |                                                                                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                         |                                                                                                                                                | 23b. DATE<br><b>5/22/86</b>                                                        |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem</b>                                                                                  |                                                                                                 |                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brooklyn A.A. Md.</b> |                                                                                                           |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Chas. A. Rice FSPA 1300 Eutaw Place</b>                                                                                                                                                                                                                                                                                                                                                     |  |                         |                                                                                                                                                |                                                                                    |                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 29 1986</b>                                                                                           |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>          |                                                                        |                                                                                                           |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. WITH FORM PM. 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6  
REG. NO.

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|                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |                                                               |                                                                                                                                                             |                                |                                                                                 |                                                                                                 |                                                                                                                            |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>EUGENE C THOMPSON                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>05 24 '86              |                                                                                                                                                             |                                | 2b. HOUR<br>5 P M                                                               |                                                                                                 |                                                                                                                            |                                              |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>WHITE                                                                                                                           |                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02 29 20                                                                                                              |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                      |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>North Carolina                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                     |                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                       |                                                                                                 |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore Gen. Hospital |                                                               |                                                                                                                                                             |                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Electrician |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction                                                                          |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                             |  |                                                                                                                                            | 13b. COUNTY<br>Baltimore                                      |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore |                                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George A. Thompson                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Beulah Byers |                                                                                                                                                             |                                | 13e. STREET ADDRESS / ZIP CODE<br>3806 Pennington Ave 21226                     |                                                                                                 |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>WW II 237-10-4978                                                              |                                                               | 17. INFORMANT<br>Ellen J. Thompson                                                                                                                          |                                |                                                                                 | ADDRESS<br>Same as 13e                                                                          |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>GANGRENE of Small Bowel</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Esophageal rupture</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                            |                                                               |                                                                                                                                                             |                                |                                                                                 |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                             |  |                                                                                                                                            |                                                               |                                                                                                                                                             |                                |                                                                                 |                                                                                                 |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION<br>4/4/86 / 5/21/86                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Esophageal rupture                                                                     |                                                               |                                                                                                                                                             |                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                 |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                |                                                                                 |                                                                                                 |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)                                                                       |                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                |                                                                                 |                                                                                                 |                                                                                                                            |                                              |
| 22a. I certify that (1) (this hospital) attended the deceased from 4/13/86 to 5/24/86, that (2) (we) lost<br>saw the deceased alive on 5/24/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) did (did not) view the body after death.                                                                             |  |                                                                                                                                            |                                                               |                                                                                                                                                             |                                |                                                                                 |                                                                                                 |                                                                                                                            |                                              |
| 22b. SIGNATURE<br>Kwang N. Kim                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                            |                                                               | DEGREE<br>MD                                                                                                                                                |                                |                                                                                 |                                                                                                 | 22c. DATE SIGNED<br>5-24-86                                                                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KWANG N. KIM, MD                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            |                                                               | 22e. ADDRESS<br>3001 S. HANOVER ST. 21225                                                                                                                   |                                |                                                                                 |                                                                                                 |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br>5/28/86                                                                                                                       |                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery                                                                                                  |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore                         |                                                                                                 |                                                                                                                            |                                              |
| 24. FUNERAL DIRECTOR<br>George J. Gonce 4001 Ritchie Hwy Balto Md                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                            |                                                               | 25a. DATE REC'D. BY REGISTRAR<br>MAY 27 1986                                                                                                                |                                | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Henderson                           |                                                                                                 |                                                                                                                            |                                              |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

2023 COINTEGRATION

2023 COINTEGRATION



00-08337

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be detached for use as the burial-transit permit. The funeral director should be detached for use as the burial-transit permit. IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |  |                                                                                                                                                             |                                                            |                                                                                                                                            |                                                              |                                                                                                                            |                                                                                              |                                                  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                 |  | 8 6                                                                                                                                  |  | 1 4 2 2 1                                                                                                                                                   |                                                            | REG. NO.                                                                                                                                   |                                                              |                                                                                                                            |                                                                                              |                                                  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>HAROLD THORNTON                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                      |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>MAY 31, 1986           |                                                                                                                                            |                                                              | 2b. HOUR<br>10:05pm                                                                                                        |                                                                                              |                                                  |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>Black                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 7 07                                                                                                                   |                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.                                                                                                 |                                                              | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                 |                                                                                              |                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                                 |                                                              |                                                                                                                            |                                                                                              |                                                  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |                                                                                                                                                             |                                                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer                                                                   |                                                              | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth Steel                                                                            |                                                                                              |                                                  |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      |  |                                                                                                                                                             | 13b. COUNTY                                                |                                                                                                                                            | 13c. CITY OR TOWN<br>Baltimore                               |                                                                                                                            | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Nathan Thornton                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lucy Watkins |                                                                                                                                            |                                                              |                                                                                                                            |                                                                                              |                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>213-07-6384                                                                                              |  | 17. INFORMANT ADDRESS<br>Annie R. Thornton 1026 Valley Street                                                                                               |                                                            |                                                                                                                                            |                                                              |                                                                                                                            |                                                                                              |                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acidosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                |  |                                                                                                                                      |  |                                                                                                                                                             |                                                            |                                                                                                                                            |                                                              |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 hrs<br>3 days                              |                                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><u>Anemia, Atrial fibrillation, Dehydration, Decubitus</u>                                                                                                                                                                                     |  |                                                                                                                                      |  |                                                                                                                                                             |                                                            |                                                                                                                                            |                                                              |                                                                                                                            |                                                                                              |                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  |                                                                                                                                                             |                                                            | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                       |                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                              |                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                            |                                                                                                                                            |                                                              |                                                                                                                            |                                                                                              |                                                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                            |                                                                                                                                            |                                                              |                                                                                                                            |                                                                                              |                                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/18</u> , 19 <u>86</u> , to <u>5/31</u> , 19 <u>86</u> , that (I) <u>we</u> last saw the deceased alive on <u>5/31</u> , 19 <u>86</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) <u>did not</u> view the body after death. |  |                                                                                                                                      |  |                                                                                                                                                             |                                                            |                                                                                                                                            |                                                              |                                                                                                                            |                                                                                              |                                                  |  |
| 22b. SIGNATURE<br><u>Victor Chang</u>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                      |  | DEGREE<br>MD                                                                                                                                                |                                                            | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                              | 22c. DATE SIGNED<br>5/31/86                                                                                                |                                                                                              |                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Victor Chang</u>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |  | 22e. ADDRESS<br>600 N WOLFE ST BALTO, MD 21205<br><u>Johns Hopkins Hospital</u>                                                                             |                                                            |                                                                                                                                            |                                                              |                                                                                                                            |                                                                                              |                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br>6/4/86                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest VA                                                                                                    |                                                            |                                                                                                                                            | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Owings Mills, Md. |                                                                                                                            |                                                                                              |                                                  |  |
| 24. FUNERAL DIRECTOR NAME<br>March Funeral Homes                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      |  |                                                                                                                                                             | 1101 East North Avenue                                     |                                                                                                                                            |                                                              | 25a. DATE REC'D. BY REGISTRAR<br>JUN 3 1986                                                                                |                                                                                              | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |  |



Handwritten notes and signatures at the bottom of the page, including a date "10/15/72" and a signature "J. H. [illegible]".

~~MAY 8 1986~~

UNDO

RECEIVED

WATSON



00-07224

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

14223

|                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |                                                                                                                                                                                                                                                                                              |                                                                                                                                                             |                                      |                                                                                                                                            |                                                                                      |                                                                                                                            |                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Alice</i>                                                                                                                                                                                                                                                                              |  |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>5-15-86</i>                                                                                                                                                                                                                                        |                                                                                                                                                             |                                      | 2b. HOUR<br><i>9:15A</i> M                                                                                                                 |                                                                                      |                                                                                                                            |                                                |  |
| 3. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><i>White</i>                                                                                                                      |                                                                                                                                                                                                                                                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>9 13 96</i>                                                                                                        |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><i>89</i>                                                                                        |                                                                                      | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                        |                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>                                                                                                  |                                                                                                                                                                                                                                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. City</i> MD.                                                                             |                                                                                      |                                                                                                                            |                                                |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lutheran Hospital of Md.</i> |                                                                                                                                                                                                                                                                                              |                                                                                                                                                             |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i>                                                       |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                |  |
| 13a. STATE<br><i>Md.</i>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              | 13b. COUNTY<br><i>Balto.</i>                                                                                                                                                                                                                                                                 |                                                                                                                                                             | 13c. CITY OR TOWN<br><i>Garrison</i> |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                |                                                                                                                                                             |                                      | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>                               |                                                                                      |                                                                                                                            | 16b. SOCIAL SECURITY NO.<br><i>217-07-3779</i> |  |
| 17. INFORMANT<br><i>Ms. Kathy Bell Hampstead, Md.</i>                                                                                                                                                                                                                                                                            |  |                                                                                                                                              | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>ventricular arrhythmia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Sepsis</i> |                                                                                                                                                             |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                               |                                                                                      |                                                                                                                            |                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                               |  |                                                                                                                                              |                                                                                                                                                                                                                                                                                              |                                                                                                                                                             |                                      |                                                                                                                                            |                                                                                      |                                                                                                                            |                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                             |                                                                                                                                                             |                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                         |  |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                                                                                                                                                                            |                                                                                                                                                             |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                              |                                                                                      |                                                                                                                            |                                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                        |  |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                       |                                                                                                                                                             |                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                      |                                                                                                                            |                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-21-1986</i> to <i>5-15-1986</i> , that (I) (we) lost saw the deceased alive on <i>5-15-1986</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                              |                                                                                                                                                                                                                                                                                              |                                                                                                                                                             |                                      |                                                                                                                                            |                                                                                      |                                                                                                                            |                                                |  |
| 22b. SIGNATURE<br><i>A. Mathew</i>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              | DEGREE                                                                                                                                                                                                                                                                                       |                                                                                                                                                             |                                      | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                      | 22c. DATE SIGNED<br><i>5-15-86</i>                                                                                         |                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>A. Mathew</i>                                                                                                                                                                                                                                                                        |  |                                                                                                                                              | 22e. ADDRESS<br><i>Lutheran Hospital, 730 Ashburton St. Baltimore</i>                                                                                                                                                                                                                        |                                                                                                                                                             |                                      |                                                                                                                                            |                                                                                      |                                                                                                                            |                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Removal</i>                                                                                                                                                                                                                                                                      |  |                                                                                                                                              | 23b. DATE<br><i>5-19-86</i>                                                                                                                                                                                                                                                                  |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY   |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                           |                                                                                                                            |                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Anatomy Board</i>                                                                                                                                                                                                                                                                             |  |                                                                                                                                              | ADDRESS<br><i>Balto., Md.</i>                                                                                                                                                                                                                                                                |                                                                                                                                                             |                                      | 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 21 1986</i>                                                                                        |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><i>John F. ...</i>                                                                           |                                                |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. (If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. (If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP



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421 1 18-21-21

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00-0702

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14224

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |  |                                                                                                                                                 |  |                                                                                                                           |  |                                                                 |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|----------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>ESTELLE</b>                                                                                                                                                                                                                                                                                                                                          |  | FIRST<br><b>TILGHMAN</b>                                                                                                             |  | LAST<br><b>TILGHMAN</b>                                                                                                                         |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/15/86</b>                                                                      |  | 2b HOUR<br><b>3:48P</b>                                         |                                              |
| 3 SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                        |  | 4 RACE<br><b>BLACK</b>                                                                                                               |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05-15-86</b>                                                                                            |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS                                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                              |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                            |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                                           |  |                                                                 |                                              |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Sacours Hosp.</b> |  |                                                                                                                                                 |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DOMESTIC</b>                                        |  | 12b KIND OF BUSINESS OR INDUSTRY                                |                                              |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                  |  | 13b COUNTY<br><b>BALTIMORE</b>                                                                                                       |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                            |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e STREET ADDRESS / ZIP CODE<br><b>855 HARLEM AVENUE 21201</b> |                                              |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES</b>                                                                                                                                                                                                                                                                                                                                       |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MAGGIE</b>                                                                        |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                                                                   |  |                                                                                                                           |  |                                                                 |                                              |
| 16b SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                       |  | 17 INFORMANT ADDRESS<br><b>CHARLOTTE TILGHMAN 855 HARLEM AVENUE</b>                                                                  |  |                                                                                                                                                 |  |                                                                                                                           |  |                                                                 |                                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>SEPSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CHRONIC PYELONEPHRITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                      |  |                                                                                                                                                 |  |                                                                                                                           |  |                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>SEIZURE DISORDER, CVA'S, ESRD ON DIALYSIS, HYPERTENSION, DEGENERATIVE</b>                                                                                                                                                                               |  |                                                                                                                                      |  |                                                                                                                                                 |  |                                                                                                                           |  |                                                                 |                                              |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                         |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                 |                                              |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                       |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                     |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                    |  |                                                                                                                           |  |                                                                 |                                              |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                      |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                |  |                                                                                                                           |  |                                                                 |                                              |
| 22a I certify that (I) (the hospital) attended the deceased from <b>5/5/86</b> to <b>5/15/1986</b> , that (I) (we) last saw the deceased alive on <b>5/15</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                                                                 |  |                                                                                                                                      |  |                                                                                                                                                 |  |                                                                                                                           |  |                                                                 |                                              |
| 22b SIGNATURE<br><b>HARI K. BHASIN</b>                                                                                                                                                                                                                                                                                                                                                        |  | DEGREE<br><b>MD</b>                                                                                                                  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>      |  |                                                                                                                           |  | 22c DATE SIGNED<br><b>5/16/86</b>                               |                                              |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HARI K. BHASIN MD FA</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |  | 22e ADDRESS<br><b>606 HAMMONDS LANE BALTO 21225</b>                                                                                             |  |                                                                                                                           |  |                                                                 |                                              |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                     |  | 23b DATE<br><b>05-21-86</b>                                                                                                          |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK CEMETERY</b>                                                                                |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MARYLAND</b>                                                   |  |                                                                 |                                              |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>BROWN/THOMPSON F.H.</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                      |  | ADDRESS<br><b>1913 W. BALTO. STREET</b>                                                                                                         |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAY 20 1986</b>                                                                        |  | 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                 |                                              |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose in the envelope. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner at the request of coroner.

BP

10-155

10-155



00-07082

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then place in the container. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, entombment, or cremation.

IMPORTANT: If item 21 is marked on item 18 above any injury, or other significant event, the medical examiner must be notified about it.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 2 5

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                        |                                                                                                                                                             |                                                                                    |                                                                                |                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FREDERICK MILTON TINSLEY SR.</b>                                                                                                                                                                                                                                                                            |                                                                                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-14-86</b>                              |                                                                                | 2b. HOUR<br><b>8:00<sup>am</sup></b>                                                                                          |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br><b>Caucasian</b>                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-18-1906</b>                                                                                                      |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                              |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VA.</b>                                                                                                                                                                                                                                                                                                                 | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |                                                                                                                               |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4807 Sinclair Lane</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Foreman</b> |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Paper Box</b>                                                                         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                   |                                                                                                                                        |                                                                                                                                                             | 13b. COUNTY<br><b>Baltimore</b>                                                    | 13c. CITY OR TOWN<br><b>Baltimore</b>                                          |                                                                                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Eugene Tinsley</b>                                                                                                                                                                                                                                                                                                            |                                                                                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucy Marydu</b>                |                                                                                |                                                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                          |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br><b>223-01-6392</b>                                                                                                              |                                                                                    | 17. INFORMANT<br>ADDRESS<br><b>Catherine Tinsley 4807 Sinclair Lan.</b>        |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic C-V disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>generalized arteriosclerosis, &amp; infarction of myocardium</b>                     |                                                                                                                                        |                                                                                                                                                             |                                                                                    |                                                                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Parkinson's disease</b>                                                                                                                                                                                                           |                                                                                                                                        |                                                                                                                                                             |                                                                                    |                                                                                |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                   |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                               |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                        |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/23</b> , 19 <b>71</b> , to <b>April 28</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>April 28</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                        |                                                                                                                                                             |                                                                                    |                                                                                |                                                                                                                               |
| 22b. SIGNATURE<br><b>Romulo V. Goco, M.D.</b>                                                                                                                                                                                                                                                                                                                              |                                                                                                                                        | DEGREE<br><b>M.D.</b>                                                                                                                                       |                                                                                    | 22c. DATE SIGNED<br><b>5/16/86</b>                                             |                                                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Romulo Goco</b>                                                                                                                                                                                                                                                                                                            |                                                                                                                                        | 22e. ADDRESS<br><b>5500 Bowleys Lane</b>                                                                                                                    |                                                                                    |                                                                                |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                              | 23b. DATE<br><b>5-17-86</b>                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>                                                                                             |                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>            |                                                                                                                               |
| 24. FUNERAL DIRECTOR<br><b>Schmunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane, Balto., Md. 21213</b>                                                                                                                                                                                                                                                                   |                                                                                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 20 1986</b>                                |                                                                                | 25b. REGISTRAR'S SIGNATURE<br><b>Richard Randall</b>                                                                          |

MEDICAL CERTIFICATION

BP

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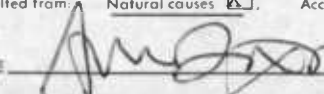
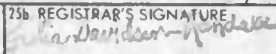


8

00-05612

FOR STATE REGISTRAR  
Items #5,6 G 615  
5/5/86 cwSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 4 2 2 6

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |  |                                                        |  |                                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|--------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |                  | FIRST                                                                                                                                |  | MIDDLE                                                                                                                                                      |  | LAST                                                                                            |  | 2a. DATE KNOWN OF ESTI.<br>DEATH MATED <input checked="" type="checkbox"/> 5 1 1986 |  |                                                        |  | 2b. HOUR<br>M                                                                                                       |  |
| HARRY                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  | L.                                                                                                                                   |  | TOMLINSON                                                                                                                                                   |  |                                                                                                 |  |                                                                                     |  |                                                        |  |                                                                                                                     |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 06 17                                                                                       |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>69 YRS.                                                                                                               |  | IF UNDER 1 YR.<br>MONTHS DAYS                                                                   |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                      |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5 3 1986 |  | 7d. HOUR<br>P M<br>5:41 P M                                                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                    |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City                                          |  |                                                                                     |  |                                                        |  |                                                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1125 W. 36th St. 21211 |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |  |                                                        |  |                                                                                                                     |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |  |                                                        |  |                                                                                                                     |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 13b. COUNTY<br>---                                                                                                                   |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1125 W. 36th Street 21211                                    |  |                                                        |  |                                                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>(unknown)                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>(unknown)                                                                                                  |  |                                                                                                 |  |                                                                                     |  |                                                        |  |                                                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>yes                                                                                                                                                                                                                                                                                                                                                             |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>(unknown) 213-18-1640A                                                    |  | 17. INFORMANT<br>ADDRESS<br>Ida Martin 1107 Roland Heights Ave. 21211                                                                                       |  |                                                                                                 |  |                                                                                     |  |                                                        |  |                                                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |                  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |  |                                                        |  |                                                                                                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |  |                                                        |  |                                                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |  |                                                                                                 |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                        |  |                                                                                                                     |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  |                                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |  |                                                        |  |                                                                                                                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                 |  |                                                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |                                                        |  |                                                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                     |  |                                                        |  |                                                                                                                     |  |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                      |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                                                                                                          |  |                                                                                                 |  | DATE SIGNED<br>5-4-86                                                               |  |                                                        |  |                                                                                                                     |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                      |  | ADDRESS<br>111 Penn St., Balto., MD 21201                                                                                                                   |  |                                                                                                 |  |                                                                                     |  |                                                        |  |                                                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Cremation                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                      |  | 23b. DATE<br>5/6/86                                                                                                                                         |  |                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Cemetery                          |  |                                                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz, Jr.                                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                      |  | ADDRESS<br>3818 Roland Ave. 21211                                                                                                                           |  |                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 5 1986                                         |  |                                                        |  | 25b. REGISTRAR'S SIGNATURE<br> |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RMY-500, "CERTAIN PAGES OF YOUR FILES TO FUNERAL DIRECTOR". PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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25MBP  
DHMH - 17  
(VR A15 ME (5))

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WILSON

AND





00-06761

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the decedent be located and be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please return the above card to the State Department of Health and Mental Hygiene with the State Death Certificate.  
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                              |  |                                            |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                |                                                  |                                                                                      |                                                                                                 | REG. NO. 86 14227                                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Claude (Thompkins)</b>                                                                                                                                                                                                                                                                             |  |                                            |                                                                                                                                    |                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 10 86</b>                                                                                                       |                                                                                |                                                  |                                                                                      |                                                                                                 | 2b. HOUR<br>A M<br><b>6:24</b>                                                                                                |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>black</b>                    |                                                                                                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 1 04</b>                    |                                                                                                                                                             |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS |                                                                                      |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |                                                                                                                                    |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                |                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                    |                                                                                                 |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                     |  |                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |                                                                        |                                                                                                                                                             |                                                                                |                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |  |
| 13a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                           |  |                                            |                                                                                                                                    |                                                                        | 13b. COUNTY                                                                                                                                                 |                                                                                | 13c. CITY OR TOWN<br><b>Baltimore</b>            |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joe Thompkins</b>                                                                                                                                                                                                                                                                                                    |  |                                            |                                                                                                                                    |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Vina Monday</b>                                                                                         |                                                                                |                                                  |                                                                                      |                                                                                                 | 13e. STREET ADDRESS / ZIP CODE<br><b>2416 Eutaw Place 21217</b>                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                 |  |                                            | 16b. SOCIAL SECURITY NO.<br><b>217-22-2730</b>                                                                                     |                                                                        |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Elizabeth Thompkins 2416 Eutaw Pl</b>           |                                                  |                                                                                      |                                                                                                 |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Malnutrition</b>                                                                                 |  |                                            |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                |                                                  |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                              |  |                                            |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                |                                                  |                                                                                      |                                                                                                 |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                            |  |                                            |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                |                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  |                                            |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) |                                                  |                                                                                      |                                                                                                 |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                      |  |                                            |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                  |                                                                                      |                                                                                                 |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/1</b> , 19 <b>86</b> , to <b>5/10</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/10</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                            |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                |                                                  |                                                                                      |                                                                                                 |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Michael A Sylva</b> MD                                                                                                                                                                                                                                                                                                                       |  |                                            |                                                                                                                                    |                                                                        |                                                                                                                                                             | 22c. DATE SIGNED<br><b>5/10/86</b>                                             |                                                  |                                                                                      | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL SYLVA</b>                                   |                                                                                                                               |  |
| 22e. ADDRESS<br><b>MERCY HOSPITAL 301 ST. Paul Pl. Baltimore</b>                                                                                                                                                                                                                                                                                                  |  |                                            |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                |                                                  |                                                                                      |                                                                                                 |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                     |  |                                            | 23b. DATE<br><b>5/16/86</b>                                                                                                        |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn Cemetery</b>                                                                                             |                                                                                |                                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>Baltimore MD</b>                          |                                                                                                 |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>March Funeral Home West 4300 Wabash Avenue</b>                                                                                                                                                                                                                                                                         |  |                                            |                                                                                                                                    |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 16 1986</b>                            |                                                  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>                                   |                                                                                                 |                                                                                                                               |  |



Elmer H. Torphim 2412 1917

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 1 4 2 2 8

|                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                                                 |                                                                                                                            |                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--|
| 1. DECEASED NAME<br>FIRST MIDDLE LAST<br>Vanessa Toney                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 4, 1986                     |                                                                                                                                                             |                                                                                                                                                      | 2b. HOUR<br>4:40 AM                                                                  |                                                                                                 |                                                                                                                            |                                                               |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br>Black                                                                                                                   |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 28 1965                                                                                                            |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>20 YRS.                                           |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |                                                                                                 |                                                                                                                            |                                                               |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3935 Edmondson Avenue |                                                                        |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Disabled         |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                               |  |
| 13a. STATE<br>Md                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    | 13b. COUNTY                                                            |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                                                                                                                       |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br>3935 Edmondson Avenue 21229 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Benjamin Toney                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bertina Milburn       |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                                                 |                                                                                                                            |                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-90-0955 |                                                                                                                                                             | 17. INFORMANT ADDRESS<br>Bertina Milburn 3935 Edmondson Avenue                                                                                       |                                                                                      |                                                                                                 |                                                                                                                            |                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC RENAL CELL CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } <u>44RS</u> |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                                                 |                                                                                                                            |                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                |  |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                                      |                                                                                                 |                                                                                                                            |                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                         |  |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                      |                                                                                                 |                                                                                                                            |                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>82</u> , to <u>4 MAY</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4 MAY</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.                                           |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                                                                                                 |                                                                                                                            |                                                               |  |
| 22b. SIGNATURE<br><u>Brian J. Corden MD</u>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                      | 22c. DATE SIGNED<br><u>5/5/86</u>                                                               |                                                                                                                            |                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>BRIAN J. CORDEN MD</u>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><u>JOHNS HOPKINS HOSPITAL</u>                                                                                                        |                                                                                      |                                                                                                 |                                                                                                                            |                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    | 23b. DATE<br>5/10/86                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt Auburn Cemetery                                                                                             |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                                      |                                                                                                                            |                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H 4300 Wabash Avenue                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>MAY 8 1986                                                                                                          |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><u>Jane Gordon</u>                                                |                                                                                                                            |                                                               |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, pages should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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POX-COT-OM SHEET



CHIEF W/ALPHABET

0-05948

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 2 2 9

|                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                         |                                                                |                                                                                                                                                            |  |                                                                                                                |  |                                                                                     |                                                                     |                                                                                                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Florence N. TONGUE</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                         | 2a DATE OF DEATH<br>MONTH <b>5</b> DAY <b>5</b> YEAR <b>86</b> |                                                                                                                                                            |  | 2b HOUR<br><b>6:55</b> AM                                                                                      |  |                                                                                     |                                                                     |                                                                                                                              |  |
| 3 SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                         |  | 4 RACE<br><b>BLACK</b>                                                                                                  |                                                                | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>27</b> YEAR <b>1896</b>                                                                                          |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.                                                               |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                    |                                                                     | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b>                                                                              |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                    |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                          |                                                                | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                               |  |                                                                                     |                                                                     |                                                                                                                              |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Keswick</b> |                                                                |                                                                                                                                                            |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>                                 |  |                                                                                     | 12b KIND OF BUSINESS OR INDUSTRY<br><b>A. County PUBLIC SCHOOLS</b> |                                                                                                                              |  |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                         |                                                                |                                                                                                                                                            |  | 13b COUNTY<br><b>Baltimore</b>                                                                                 |  | 13c CITY OR TOWN<br><b>Baltimore</b>                                                |                                                                     | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 14 FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b>Henry</b> LAST <b>Norris</b>                                                                                                                                                                                                                                                                                 |  |                                                                                                                         |                                                                |                                                                                                                                                            |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Perlimer</b> MIDDLE <b>Campbell</b> LAST <b>Norris</b>                     |  |                                                                                     |                                                                     |                                                                                                                              |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No.</b>                                                                                                                                                                                                                                                                                 |  |                                                                                                                         |                                                                | 16b SOCIAL SECURITY NO.<br><b>214-38-1310</b>                                                                                                              |  | 17 INFORMANT<br><b>2129 Division Street</b><br><b>Augustus Tongue Baltimore, Maryland 21217</b>                |  |                                                                                     |                                                                     |                                                                                                                              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral contusion</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cervical cord (C5-68) damage</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 months</b>                                                                        |  |                                                                                                                         |                                                                |                                                                                                                                                            |  |                                                                                                                |  |                                                                                     |                                                                     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>                                                                                                                                                                                                                      |  |                                                                                                                         |                                                                |                                                                                                                                                            |  |                                                                                                                |  |                                                                                     |                                                                     |                                                                                                                              |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                         |                                                                | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                                |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                     | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                              |  |                                                                                                                         |                                                                | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>3/6/86</b>                                                                                       |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>Fell through trap door</b> |  |                                                                                     |                                                                     |                                                                                                                              |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                            |  |                                                                                                                         |                                                                | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>store</b>                                                                      |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>700 W. 40th St. Baltimore, Maryland</b>                 |  |                                                                                     |                                                                     |                                                                                                                              |  |
| 22a I certify that (in this hospital) attended the deceased from <b>May 2</b> , 19 <b>86</b> , to <b>May 5</b> , 19 <b>86</b> , that (we) lost<br>saw the deceased alive on <b>May 5</b> , 19 <b>86</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I/we) (did) (did not) view the body after death. |  |                                                                                                                         |                                                                |                                                                                                                                                            |  |                                                                                                                |  |                                                                                     |                                                                     |                                                                                                                              |  |
| 22b SIGNATURE<br><b>W.B. Daniel, Jr.</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                         |                                                                |                                                                                                                                                            |  | DEGREE<br><b>MD</b>                                                                                            |  |                                                                                     | 22c DATE SIGNED<br><b>5/5/86</b>                                    |                                                                                                                              |  |
| 22a PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                         |                                                                |                                                                                                                                                            |  | 22e ADDRESS<br><b>Keswick 700 W. 40th St. Balto 21211</b>                                                      |  |                                                                                     |                                                                     |                                                                                                                              |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                         |                                                                | 23b DATE<br><b>5/9/1986</b>                                                                                                                                |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>St. Thomas Cemetery</b>                                                |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown, Maryland</b>          |                                                                     |                                                                                                                              |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>WYNNS FALLS FUNERAL HOME, INC.</b> ADDRESS <b>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>                                                                                                                                                                                                                                  |  |                                                                                                                         |                                                                |                                                                                                                                                            |  | 25a DATE REC'D. BY REGISTRAR <b>MAY 8 1986</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>                        |  |                                                                                     |                                                                     |                                                                                                                              |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires ~~that~~ the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 2 and place it in the box provided for the coroner or medical examiner with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposal. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic evidence, the coroner or medical examiner should be notified.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

IMPORTANT

|                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                 |  | Virginia C. Tormey                                                                                     |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                     |  | 8 6                                                                 |  | 1 4 2 3 0                                    |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                       |  |                                                                                                        |  | 2a. DATE OF DEATH                                                                                                                                        |  | MONTH DAY YEAR                                                      |  | 2b. HOUR                                     |  |
| VIRGINIA C. TORMEY                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | 05 14 86                                                                                                                                                 |  | 7 25 PM                                                             |  |                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                 |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS, LAST BIRTHDAY)                                    |  | 7. IF UNDER 1 YEAR                           |  |
| F                                                                                                                                                                                                                                                                                      |  | W                                                                                                      |  | 04 02 14                                                                                                                                                 |  | 72 YRS.                                                             |  | MONTHS DAYS HOURS MIN.                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                              |  |
| Md.                                                                                                                                                                                                                                                                                    |  | USA                                                                                                    |  |                                                                                                                                                          |  | Baltimore City MD                                                   |  |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                              |  |
| Baltimore                                                                                                                                                                                                                                                                              |  | SINAE OF BALTIMORE                                                                                     |  | Homemaker                                                                                                                                                |  |                                                                     |  |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS / ZIP CODE               |  |
| Md                                                                                                                                                                                                                                                                                     |  | Baltimore                                                                                              |  | Baltimore                                                                                                                                                |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 6132 Falls Road -21209                       |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |  |                                                                     |  |                                              |  |
| FIRST MIDDLE LAST F. Carroll Tormey                                                                                                                                                                                                                                                    |  |                                                                                                        |  | FIRST MIDDLE LAST Lillian B. Hevel                                                                                                                       |  |                                                                     |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                             |  |                                              |  |
| NO                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | Mr. Robert Adsit                                                                                                                                         |  | 6131 Falls Road                                                     |  | -09                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Hepatic encephalopathy                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Liver metastases of stomach & hepatic metastases                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                              |  |
|                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)                                                                           |  |                                                                     |  |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  | 22c. DATE SIGNED                             |  |
| FRIEDRICH J. WILSON                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  | 5/14/86                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                  |  |                                                                                                        |  | 22e. ADDRESS                                                                                                                                             |  |                                                                     |  |                                              |  |
| FRIEDRICH J. WILSON                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | SINAE OF BALTIMORE                                                                                                                                       |  |                                                                     |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                              |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |                                              |  |
| Burial                                                                                                                                                                                                                                                                                 |  | 5/17/86                                                                                                |  | Green Mount Cemetery                                                                                                                                     |  | Baltimore, Md.                                                      |  |                                              |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE            |  |                                              |  |
| MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |  | MAY 20 1986 John Davidson-Hansen                                    |  |                                              |  |





00-07990

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                          |                                            |                                                                                                                                                             |                                                                        |                                                                     |                                                                                    |                                                                                                                                                                 |                                   |                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SIDNEY TOWNS</b>                                                                                                                                                                                                                                                                                                                                               |                                            |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 23 86</b>                  |                                                                     |                                                                                    | 2b. HOUR<br><b>8:35<sup>PM</sup></b>                                                                                                                            |                                   |                                                                                                                               |
| 3 SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                     | 4 RACE<br><b>black</b>                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 15 1921</b>                                                                                                      |                                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                   |                                                                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                                                                                                                    |                                   | IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b>                                                                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>                                                                                                                                                                                                                                                                                                                                                 | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.   |                                                                                    |                                                                                                                                                                 |                                   |                                                                                                                               |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                            |                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC BALTIMORE, MARYLAND 21218</b>          |                                                                        |                                                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |                                                                                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                                                                               |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                  |                                            |                                                                                                                                                             |                                                                        |                                                                     |                                                                                    |                                                                                                                                                                 |                                   |                                                                                                                               |
| 13a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                                                  |                                            | 13b. COUNTY                                                                                                                                                 |                                                                        | 13c. CITY OR TOWN<br><b>Baltimore</b>                               |                                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                 |                                   |                                                                                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jurell Towns</b>                                                                                                                                                                                                                                                                                                                                            |                                            |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucy Stewart</b>   |                                                                     |                                                                                    |                                                                                                                                                                 |                                   |                                                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                       |                                            | 16b. SOCIAL SECURITY NO.<br><b>242 20 1552</b>                                                                                                              |                                                                        | 17. INFORMANT ADDRESS<br><b>Beatrice Towns 2906 W. North Avenue</b> |                                                                                    |                                                                                                                                                                 |                                   |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Shy Drager Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypoalbuminemic</b>                                                                                                               |                                            |                                                                                                                                                             |                                                                        |                                                                     |                                                                                    |                                                                                                                                                                 |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)                                                                                                                                                                                                                                                                     |                                            |                                                                                                                                                             |                                                                        |                                                                     |                                                                                    |                                                                                                                                                                 |                                   |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                   |                                            |                                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                     |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                       |                                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                 |                                            |                                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |                                                                                                                                                                 |                                   |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                             |                                            |                                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |                                                                                                                                                                 |                                   |                                                                                                                               |
| 22a. I certify that (I, <del>we</del> this hospital) attended the deceased from <b>APRIL 30</b> , 19 <b>86</b> , to <b>MAY 23</b> , 19 <b>86</b> , that (I, <del>we</del> ) saw the deceased alive on <b>MAY 23</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I, <del>we</del> ) (did) (did not) view the body after death. |                                            |                                                                                                                                                             |                                                                        |                                                                     |                                                                                    |                                                                                                                                                                 |                                   |                                                                                                                               |
| 22b. SIGNATURE<br><b>Mary T Behrens MD</b>                                                                                                                                                                                                                                                                                                                                                               |                                            |                                                                                                                                                             |                                                                        |                                                                     |                                                                                    | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED<br><b>5-24-86</b>                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mary T Behrens</b>                                                                                                                                                                                                                                                                                                                                           |                                            |                                                                                                                                                             | 22e. ADDRESS<br><b>Loch Raven VA Hospital</b>                          |                                                                     |                                                                                    |                                                                                                                                                                 |                                   |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                            |                                            | 23b. DATE<br><b>5/29/86</b>                                                                                                                                 |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>     |                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>                                                                                               |                                   |                                                                                                                               |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>March Funeral Home West 4300 Wabash Avenue</b>                                                                                                                                                                                                                                                                                                                        |                                            |                                                                                                                                                             |                                                                        | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 29 1986</b>                 |                                                                                    | 25b. REGISTRAR'S SIGNATURE<br><b>Gutha Davidson-Randall</b>                                                                                                     |                                   |                                                                                                                               |

BP

PLANT INDUSTRY

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

00-07215

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 2 and 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 3 2

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                           |                                                     |                                                                                                                                                             |                       |                                                                                                 |  |                                                                                                                            |  |                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR<br>DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Lydia S. Townsend                                                                                                                                                                                                                                                                 |  |                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 16, 1986 |                                                                                                                                                             | 2b. HOUR<br>6:55 P.M. |                                                                                                 |  |                                                                                                                            |  |                                                                                 |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>White                                                                                                          |                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 30 1903                                                                                                            |                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS                                                       |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |  | 8. IF UNDER 24 HRS.                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                    |                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |                                                                                                                            |  |                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital |                                                     |                                                                                                                                                             |                       | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Maintenance                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. City Hosp                                                                      |  |                                                                                 |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY<br>Baltimore                                                                                                  |                                                     | 13c. CITY OR TOWN<br>Dundalk                                                                                                                                |                       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>8405 Kavanagh Road 21222                                                                 |  |                                                                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Andrew Baumes                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary H. Connolly                                                         |                                                     | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                         |                       |                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>218-03-6261                                                                                    |  | 17. INFORMANT<br>ADDRESS<br>William H. Townsend 187 Alstun Road Balto. MD 21221 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) CARDIOGENIC SHOCK<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                           |                                                     |                                                                                                                                                             |                       |                                                                                                 |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                              |  |                                                                                                                           |                                                     |                                                                                                                                                             |                       |                                                                                                 |  |                                                                                                                            |  |                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                          |                                                     |                                                                                                                                                             |                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                |                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                       |                                                                                                 |  |                                                                                                                            |  |                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                    |                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                       |                                                                                                 |  |                                                                                                                            |  |                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 14, 1986, to MAY 16, 1986, that (I) (we) last saw the deceased alive on MAY 16, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                             |  |                                                                                                                           |                                                     |                                                                                                                                                             |                       |                                                                                                 |  |                                                                                                                            |  |                                                                                 |  |
| 22b. SIGNATURE<br>SAJDI M.D.                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                           |                                                     |                                                                                                                                                             |                       |                                                                                                 |  |                                                                                                                            |  | 22c. DATE SIGNED<br>5/16/86                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                               |  |                                                                                                                           |                                                     | 23b. DATE<br>5/19/86                                                                                                                                        |                       | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                                           |  |                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Duda-Ruck, Inc. 7922 Wise Avenue, Dundalk, MD 21222                                                                                                                                                                                                                                                                       |  |                                                                                                                           |                                                     |                                                                                                                                                             |                       | 25a. DATE REC'D BY REGISTRAR<br>MAY 21 1986                                                     |  | 25b. REGISTRAR'S SIGNATURE<br>Walter R. Riddle                                                                             |  |                                                                                 |  |

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00-08099

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 1 4 2 3 3

|                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                                                                                                           |                                                                                                 |                                                                         |                                                                                                                            |                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARGARET T. TRACEY</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/27/86</b>                  |                                                                                                                                                             |                                                                                                                                                                           | 2b. HOUR<br><b>4<sup>30</sup> A.M.</b>                                                          |                                                                         |                                                                                                                            |                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>White</b>                                                                                                                   |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 20 1909</b>                                                                                                      |                                                                                                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS                                                |                                                                         | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                                                                               |                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.                                   |                                                                         |                                                                                                                            |                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mason F. Ford (FSKMC)</b> |                                                                        |                                                                                                                                                             |                                                                                                                                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Housewife</b>             |                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                            |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                                                                                                           |                                                                                                 |                                                                         |                                                                                                                            |                                                                            |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                           |                                                                        | 13c. CITY OR TOWN<br><b>Essex</b>                                                                                                                           |                                                                                                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                         | 13e. STREET ADDRESS / ZIP CODE<br><b>708 Mansfield Road 21221</b>                                                          |                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John E. Kelly</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                           |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie Flynn</b>                                                                                                      |                                                                                                 |                                                                         |                                                                                                                            |                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                      |  |                                                                                                                                           | 16b. SOCIAL SECURITY NO<br><b>214-18-3524</b>                          |                                                                                                                                                             | 17. INFORMANT<br><b>Edward J. Mitchell, Sr.</b>                                                                                                                           |                                                                                                 |                                                                         | ADDRESS<br><b>Same as 13e</b>                                                                                              |                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsicemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last              |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                                                                                                           |                                                                                                 |                                                                         |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>hrs.</b><br><b>nos.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                 |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                                                                                                           |                                                                                                 |                                                                         |                                                                                                                            |                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                                                                                            |                                                                                                 |                                                                         |                                                                                                                            |                                                                            |  |
| 21d. INJURY OCCURRED<br>AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/><br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>                                                                                                                                                                                                    |  |                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                         |                                                                                                 |                                                                         |                                                                                                                            |                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/30</b> , 19 <b>82</b> , to <b>5/27</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/27</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                                                                                                           |                                                                                                 |                                                                         |                                                                                                                            |                                                                            |  |
| 22b. SIGNATURE<br><b>E. ROGERS, M.D.</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                           |                                                                        |                                                                                                                                                             | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>3/28/86</b>                                      |                                                                                                                            |                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                           |                                                                        |                                                                                                                                                             | 22e. ADDRESS                                                                                                                                                              |                                                                                                 |                                                                         |                                                                                                                            |                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           | 23b. DATE<br><b>5/30/1986</b>                                          |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>                                                                                                                |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |                                                                                                                            |                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |                                                                        |                                                                                                                                                             | ADDRESS<br><b>7922 Wise Avenue Dundalk, Maryland 21222</b>                                                                                                                |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 2 1986</b>                      |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><b>John E. Mitchell, Sr.</b>                 |  |

MEDICAL CERTIFICATION

9-90-93-130-132

2-9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove contents of pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



Project T. 1964

1964

1964

1964





06-05803

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14234

REG. NO.

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                    |  |                                                                                                                                                             |                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSIF TRAKHTENBERG</b>                                                                                                                                                                                                                                                                                                     |                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05-02-86</b>                             |  | 2b. HOUR<br><b>11:25</b> AM                                                                                                                                 |                                                             |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                             | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPT. 6, 1918</b>                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                                                                                           |                                                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>                                                                                                                                                                                                                                                                                                        |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                             |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                                                                                                                                                                                                                                                 |                         | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINDALE HEBREW HOME</b>                   |                                                             |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                     |                         | 13b. COUNTY<br><b>BALTIMORE</b>                                                    |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |                                                             |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ZACKERY TRAKHTENBERG</b>                                                                                                                                                                                                                                                                                             |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>GITTEL VISHNIVETSKY</b>        |  | 16. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CHEMICAL ENGINEER WILLIAMS PAINT CO.</b>                                              |                                                             |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                 |                         | 17b. SOCIAL SECURITY NO.<br><b>219-80-8829</b>                                     |  | 17c. INFORMANT<br><b>MRS. FANNY TRAKHTENBERG</b><br><b>212 HAWTHORNE AVE. #21208</b>                                                                        |                                                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>METASTATIC CA of the COLON</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                         |                                                                                    |  |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7/85</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>SEPSIS, OBSTRUCTIVE NEPHROPATHY</b>                                                                                                                                                                                    |                         |                                                                                    |  |                                                                                                                                                             |                                                             |
| 19a. DATE OF OPERATION<br><b>05-01-86</b>                                                                                                                                                                                                                                                                                                                         |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>OBSTRUCTIVE NEPHROPATHY</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                             |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                         |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>05-01-86</b> to <b>05-02-86</b> , that (I) (we) last saw the deceased alive on <b>05-02-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |                         |                                                                                    |  |                                                                                                                                                             |                                                             |
| 22b. SIGNATURE<br><b>H. M. W. S.</b>                                                                                                                                                                                                                                                                                                                              |                         | DEGREE<br><b>MD</b>                                                                |  | 22c. DATE SIGNED<br><b>05-02-86</b>                                                                                                                         |                                                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. ZAW-WIN, MD</b>                                                                                                                                                                                                                                                                                                    |                         | 22e. ADDRESS<br><b>Levinson &amp; Bros. Inc. 21215</b>                             |  |                                                                                                                                                             |                                                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                        |                         | 23b. DATE<br><b>5-4-86</b>                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON-CHIZUK AMUNO</b>                                                                                         |                                                             |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>                                                                                                                                                                                                                                                                                             |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 6 1986</b>                                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>James Gordon Randall</b>                                                                                                   |                                                             |
| 2010 REISTERSTOWN RD., BALTO., MD 21215                                                                                                                                                                                                                                                                                                                           |                         | BALTIMORE                                                                          |  | MD                                                                                                                                                          |                                                             |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

9391

100



NEW YORK

100

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARCELLUS</b>                                                                                                                                                                                                                                                                                                                                                       |  | FIRST MIDDLE LAST<br><b>TRAPP</b>                                                                                                     |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 12 86</b>                                                                                                                                                                                                                                                                                                    |  | 2b. HOUR<br><b>256 P.M.</b>                                                                                                |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>BLACK</b>                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 31 13</b>                                                                                                                                                                                                                                                                                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>73</b>                                                                       |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Rock Hill S.C.</b>                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                              |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>V.A.H. Rock Raven</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Mason Carpenter</b>                                                                                                                                                                                                                                                          |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                       |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Geoffrey Trapp</b>                                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary</b>                                                                          |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-09-1625</b>                                              |  |
| 17. INFORMANT<br><b>Feggie Mitchell</b>                                                                                                                                                                                                                                                                                                                                                                       |  | ADDRESS<br><b>924 N. Castle St.</b>                                                                                                   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.                                                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                                                                                                                                                                                                           |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                        |  | 21g. DATE SIGNED<br><b>5/12/86</b>                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/12 1986</b> , to <b>5/12 1986</b> , that (I) <del>viewed</del> <b>viewed</b> the deceased alive on <b>5/12 1986</b> , and that in (my) <del>own</del> <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (I) <del>have</del> <b>have</b> (did) <del>not</del> <b>view</b> the body after death. |  |                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Ralph J Panos MD</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                       |  | DEGREE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                      |  | 22c. DATE SIGNED<br><b>5/12/86</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RALPH J PANOS MD</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |  | 22e. ADDRESS<br><b>LRVAH</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(S-P-R)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>5-15-86</b>                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD Veterans</b>                                                                                                                                                                                                                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville MD</b>                                                        |  |
| 24. FUNERAL DIRECTOR<br><b>Marshall Adams 6387 91/mv/86</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1986</b>                                                                                                                                                                                                                                                                                                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>Felix Borden</b>                                                                          |  |

BP\_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15. 4)



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 4 2 3 6

1- FOR  
STATE  
REGISTRAR

|                                                                                    |                     |                                                                                                                                           |                                                      |                                                                                                                                                             |  |                                                                                        |  |                                                                                                 |  |
|------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Louise Travers</b>                       |                     |                                                                                                                                           |                                                      | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>5-21 1986</b>                                                 |  |                                                                                        |  | 2b. HOUR<br>M<br><b>6:58</b>                                                                    |  |
| 3. SEX<br><b>F</b>                                                                 | 4. RACE<br><b>B</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 15 14</b>                                                                                      | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>72</b> | 7. IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>                                                                                                              |  | 7. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>                                        |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>5-21 1986</b>                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                       |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             |                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BaltimoreCity, MD.</b>                      |  |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                      |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4747 Wrenwood Avenue</b> |                                                      |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FACTORY WORKER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |
| 13a. STATE<br><b>MARYLAND</b>                                                      |                     |                                                                                                                                           |                                                      | 13b. COUNTY                                                                                                                                                 |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THOMAS E. TRAVERS</b>                 |                     |                                                                                                                                           |                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY E. GRIFFIN</b>                                                                                     |  |                                                                                        |  | 13e. STREET ADDRESS<br><b>4747 WRENWOOD AVENUE</b>                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b> |                     |                                                                                                                                           |                                                      | 16b. SOCIAL SECURITY NO.<br><b>214142431A</b>                                                                                                               |  | 17. INFORMANT ADDRESS<br><b>WILLIAM M. TRAVERS 4747 WRENWOOD AVE.</b>                  |  |                                                                                                 |  |

|                                                                                                                                                                                                                                                                                                                                                                               |  |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                   |  |                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                   |  |                                                                                     |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>                                                                                                                                                                                                                                                                                                                                                                                             |  | TITLE (SPECIFY)<br><b>Assistant</b>                               |  | DATE SIGNED<br><b>5-22-86</b>                                                       |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                        |  | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>                 |  |                                                                                     |  |

|                                                                                               |  |                             |  |                                                                   |  |                                                                             |  |
|-----------------------------------------------------------------------------------------------|--|-----------------------------|--|-------------------------------------------------------------------|--|-----------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                    |  | 23b. DATE<br><b>5-27-86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LANE CHAPEL CEMETERY</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>TAYLOR ISLAND MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WM.C.MARCH FUNERAL HOME INC. 1101 E.NORTH AVE.</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1986</b>               |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                            |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. COPIES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PHA 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMITS. PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

05450-00

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 3 7

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                                                       |                                                                                                                                       |                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM R TURNAGE SR</b>                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br><b>MAY 4, 1986</b>                                                         |                                                                                                                                                       | 2b. HOUR<br><b>03:59 am</b>                                                                                                           |                                                                                                          |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br><b>Black</b>                                                                                                                        | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>5</b> YEAR <b>29</b>                                                                                             |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b>                                                                                                          | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.                                                               |                                                                                                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>                                                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                                                                                         |                                                                                                                                       |                                                                                                          |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Fireman</b>                                                                    | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                     |                                                                                                          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                    |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                                                       |                                                                                                                                       |                                                                                                          |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                         | 13b. COUNTY                                                                                                                                    | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1724 Chilton St. 21218</b>                                                                                       |                                                                                                                                       |                                                                                                          |
| 14. FATHER'S NAME<br>FIRST <b>Adam</b> MIDDLE <b>Turnage</b> LAST <b>Turnage</b>                                                                                                                                                                                                                                                                                                                |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Elizabeth</b> MIDDLE <b>Beard</b> LAST <b>Beard</b>                                                                    |                                                                                                 |                                                                                                                                                       |                                                                                                                                       |                                                                                                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                              |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br><b>215-24-9477</b>                                                                                                              |                                                                                                 | 17. INFORMANT ADDRESS<br><b>Creolia E. Turnage 1724 Chilton St.</b>                                                                                   |                                                                                                                                       |                                                                                                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Esophageal carcinoma</b> |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                                                       |                                                                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>30 minutes</b><br><b>5 months</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Pneumonia</b>                                                                                                                                                                                                                                        |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                                                       |                                                                                                                                       |                                                                                                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                        |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                     |                                                                                                                                       |                                                                                                          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                       |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                     |                                                                                                                                       |                                                                                                          |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/30</b> , 19 <b>86</b> , to <b>5/4</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/4</b> , 19 <b>86</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.                                      |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                                                       |                                                                                                                                       |                                                                                                          |
| 22b. SIGNATURE<br><b>Cynthia S. Cramer</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                                                       | 22c. DATE SIGNED<br><b>5/4/86</b>                                                                        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Cynthia S. Cramer</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                | 22e. ADDRESS<br><b>600 N WOLFE STREET<br/>Johns Hopkins Hospital, Baltimore, MD, 21205</b>                                                                  |                                                                                                 |                                                                                                                                                       |                                                                                                                                       |                                                                                                          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                | 23b. DATE<br><b>5/8/86</b>                                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>                                 |                                                                                                                                                       | 23d. LOCATION<br>CITY OR TOWN <b>Owings Mills</b> COUNTY <b>MD</b> STATE                                                              |                                                                                                          |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H 4300 Wabash Avenue</b> ADDRESS                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                |                                                                                                                                                             |                                                                                                 | 25a. DATE RECEIVED BY REGISTRAR<br><b>MAY 5 1986</b>                                                                                                  |                                                                                                                                       |                                                                                                          |

DIVISION OF VITAL RECORDS 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



MAIL ROOM  
PROV

CIRCUIT

BOARD

X

CELL

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician indicate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return the copy to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANNA E. TYLER                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>05 20 86                               |                                                                                      | 2b. HOUR<br>4:00 A.M.                        |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br>WHITE                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 12 19                                                                                                               |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.                                           |                                              |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Med Ctr. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>---     |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                         |                                                                                                                                                             | 13b. CITY OR TOWN<br>Baltimore                                                | 13c. STREET ADDRESS<br>1129 Daniels Avenue 21207                                     |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Herbert L. Ridgely                                                                                                                                                                                                                                                                                                           |                                                                                                                                         |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Blanche E. Crist             |                                                                                      |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                                 |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>214-20-6611                                                                                                                     |                                                                               | 17. INFORMANT ADDRESS<br>Carliss Hiltner 4371 Parkton St. 21229                      |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                                         |                                                                                                                                                             |                                                                               |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                              |                                                                                                                                         |                                                                                                                                                             |                                                                               |                                                                                      |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                              |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/19/86</u> 19 <u>86</u> , to <u>5/20</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5/20</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |                                                                                                                                         |                                                                                                                                                             |                                                                               |                                                                                      |                                              |
| 22b. SIGNATURE<br><u>K Wood MD</u>                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                         | DEGREE                                                                                                                                                      |                                                                               | 22c. DATE SIGNED<br><u>5/20/86</u>                                                   |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Karen Wood MD</u>                                                                                                                                                                                                                                                                                                          |                                                                                                                                         | 22e. ADDRESS<br><u>PSKMC</u>                                                                                                                                |                                                                               |                                                                                      |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                 | 23b. DATE<br>5/22/86                                                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Mountview Cemetery                                                                                                    |                                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Marriottsville Howard Md               |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.                                                                                                                                                                                                                                                                                                             |                                                                                                                                         | ADDRESS<br>21229<br>4107 Wilkens Ave.                                                                                                                       |                                                                               | 25a. DATE RECORDED<br>MAY 21 1986                                                    |                                              |



00-074361

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 3 9

REG. NO.

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>John D. Tyre                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5/18/86                                                                                                              |  |                                                                                      |  | 2b. HOUR<br>M                                                                                                              |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>Black                                                                                                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8/12/98                                                                                                               |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>87 YRS                                          |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3118 Leeds St. (Home) |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>P.P.G Ind.                                                                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md.                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |  | 13b. COUNTY<br>Balto.                                                                                                                                       |  | 13c. CITY OR TOWN<br>Balto.                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>John D. Tyre                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>Georgieanna Tyree                                                                                                               |  |                                                                                      |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-05-3023                                                             |  | 17. INFORMANT ADDRESS<br>Jacqueline Farmer 5325 Jamestown Ct. 21229                                                                                         |  |                                                                                      |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>LEAD</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                           |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>7 INFORMED OF DEATH ON 5/18/86</u>                                                                  |  |                                                                                      |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                   |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Paul Fatterpachter</u>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |                                                                                      |  | 22c. DATE SIGNED                                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL FATTERPACHTER                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |  | 22e. ADDRESS<br>730 MAIDEN CHOICE LANE<br>CATONSVILLE 21228                                                                                                 |  |                                                                                      |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br>5/23/86                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Western Star                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Md.                        |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Chas. A. Rice FSPA 1300 Eutaw Place                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 23 1986                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson</u>                                  |  |                                                                                                                            |  |

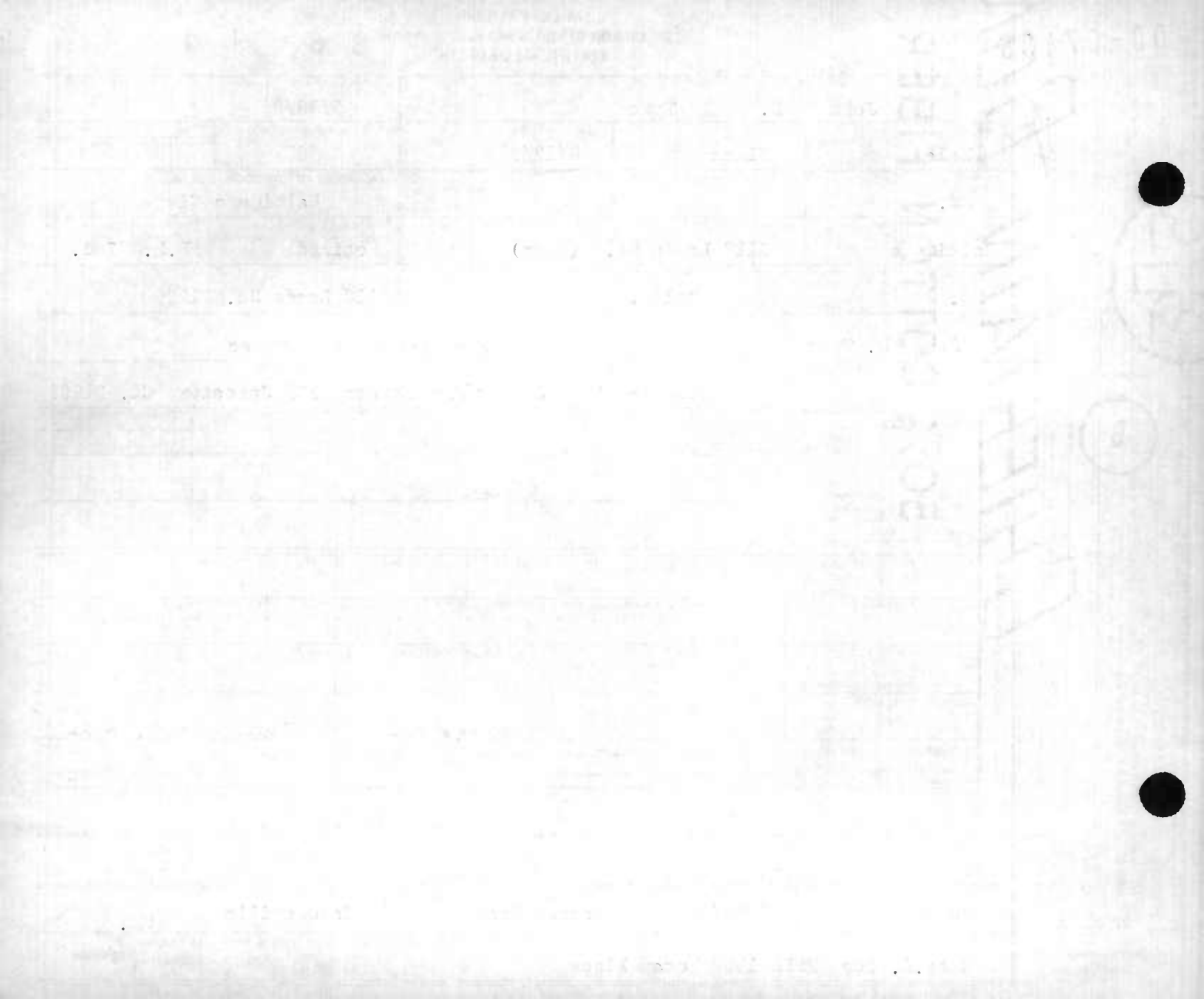
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (cut out) page 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-08127

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 4 0

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                               |                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DAVID Robert T UTLEY                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 27 86 |                                                                                                                                                             |  | 2b. HOUR<br>11 30 P M                                                                           |  |                                                                                                                            |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>BLACK                                                                                                              |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 5 20                                                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                                      |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Atlanta, Ga.                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                        |                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.                                                |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3615 Marmon Ave. |                                                |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Post office                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Govt.                                                                                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                |  |                                                                                                                               |                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY                                                                                                                   |                                                | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>3615 Marmon Ave. 21207                                                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Nishaus Utley                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                               |                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Scott                                                                                                |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII 214-12-1134                                                   |                                                | 17. INFORMANT<br>ADDRESS<br>Robert T Utley 56 Millstone Rd.                                                                                                 |  |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC COLON CANCER</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                                                               |                                                |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 MIN.<br>4 MONTHS                                                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                    |  |                                                                                                                               |                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                              |                                                |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                    |                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)                                                          |                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/3</u> , 19 <u>86</u> , to <u>5/27</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/21</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |                                                                                                                               |                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>DOROTHY SNOW                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                               |                                                | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |                                                                                                 |  | 22c. DATE SIGNED<br>5/28/86                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DOROTHY SNOW                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                               |                                                | 22e. ADDRESS<br>3900 LOCH RAVEN BLVD                                                                                                                        |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>5-31-86                                                                                                          |                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus                                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Jas. A. Morton & Sons                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                               |                                                | ADDRESS<br>1701 Laurens                                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 2 1986                                                     |  | 25b. REGISTRAR'S SIGNATURE<br>John A. ...                                                                                  |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

100% COTTON FIBRE

WILSON & JONES





00-06151

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 4 2 4 1  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                          |                                             |                                                                                                                                               |                                  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <i>Mary</i> MIDDLE <i>Agnes</i> LAST <i>Vacarium</i><br><del>xxxxxxx</del> <i>Vacar</i>                                                                                                                                                                                                                           |  |                                                                                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 10 86 |                                                                                                                                               | 2b. HOUR<br>2 <sup>00</sup> P.M. |  |
| 3. SEX<br>F Female                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>White<br>Cauc.                                                                                                                                |                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 22 08                                                                                                 |                                  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.                                                                                                                                                                                                                                                                                                                     |  | 7. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                               |                                             | 8. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                                  |                                  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                           |  | 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                   |                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Medical Center |                                  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                                                                                                                                                                                                                                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Housework                                                                                                           |                                             | 13. STREET ADDRESS<br>832 South Ponca St. 21224                                                                                               |                                  |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br>---                                                                                                                                       |                                             | 13c. CITY OR TOWN<br>Baltimore                                                                                                                |                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Gabriel Banks                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Seladie                                                                                            |                                             | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                    |                                  |  |
| 16b. SOCIAL SECURITY NO.<br>214-05-34050                                                                                                                                                                                                                                                                                                                       |  | 17. INFORMANT<br>Walter Vacar                                                                                                                            |                                             | ADDRESS<br>2326 E. Fayette St. 21224                                                                                                          |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Anterior MI</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>lt. hemispheric CVA</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |  |                                                                                                                                                          |                                             |                                                                                                                                               |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                            |  |                                                                                                                                                          |                                             |                                                                                                                                               |                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                          |                                  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                     |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                    |                                  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                                 |  | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |                                             | 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                             |                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> 19 <u>86</u> , to <u>5/10</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5/10/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                          |                                             |                                                                                                                                               |                                  |  |
| 22b. SIGNATURE<br><i>Lea Stern MD</i>                                                                                                                                                                                                                                                                                                                          |  | DEGREE                                                                                                                                                   |                                             | 22c. DATE SIGNED<br>5/10/86                                                                                                                   |                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STERN                                                                                                                                                                                                                                                                                                                 |  | 22e. ADDRESS<br>4940 Eastern Ave Baltimore MD                                                                                                            |                                             | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <u>Burial</u>                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br>5-14-86                                                                                                                                     |                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Saint Stanislaus                                                                                        |                                  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City Md.                                                                                                                                                                                                                                                                                               |  | 23e. DATE RECEIVED BY REGISTRAR<br>MAY 12 1986                                                                                                           |                                             | 23f. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                              |                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME Charles S. Zeiler & Son Inc. ADDRESS 6224 Eastern Ave.                                                                                                                                                                                                                                                                            |  |                                                                                                                                                          |                                             |                                                                                                                                               |                                  |  |

BP



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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |                                                                                                                                                                  |                                                                  |                                                                                                 |                              |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANGELINA M. VALENCIA</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             |  |                                                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>25</b> YEAR <b>86</b> |                                                                                                 | 2b. HOUR<br><b>5:10 A.M.</b> |                                                                                                                            |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>White</b>                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>02</b> YEAR <b>15</b>                                                                                                 |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                               |                              | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |                              |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSPITAL</b> |  |                                                                                                                                                                  |                                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |                              | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                                                           |  | 13b. COUNTY <b></b>                                                                                                                         |  | 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                               |                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              | 13e. STREET ADDRESS / ZIP CODE<br><b>3022 Westfield Ave. 21214</b>                                                         |  |
| 14. FATHER'S NAME<br>FIRST <b>Louis</b> MIDDLE <b></b> LAST <b>Fonte</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Veronica</b> MIDDLE <b></b> LAST <b>Porpora</b>                                                                             |                                                                  |                                                                                                 |                              |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>215-09-2101</b>                                                                                              |  | 17. INFORMANT<br>Sr. ADDRESS <b>21214</b><br><b>Samuel A. Valencia Sr. 223022 Westfield Ave.</b>                                                                 |                                                                  |                                                                                                 |                              |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Breast Carcinoma.</b>                                                                                                                                                                                                                            |  |                                                                                                                                             |  |                                                                                                                                                                  |                                                                  |                                                                                                 |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                             |  |                                                                                                                                                                  |                                                                  |                                                                                                 |                              |                                                                                                                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             |  |                                                                                                                                                                  |                                                                  |                                                                                                 |                              |                                                                                                                            |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                             |  |                                                                                                                                                                  |                                                                  |                                                                                                 |                              |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>                                                                                                                                                                                                                                                        |  |                                                                                                                                             |  |                                                                                                                                                                  |                                                                  |                                                                                                 |                              |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |  |                                                                                                                                                                  |                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                    |                                                                  |                                                                                                 |                              |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                |                                                                  |                                                                                                 |                              |                                                                                                                            |  |
| 22a. I certify that (I) ( <del>this</del> hospital) attended the deceased from <b>5/17/1986</b> to <b>5/25/1986</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>5/25/1986</b> , and that in (my) ( <del>your</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) ( <del>did not</del> ) view the body after death. |  |                                                                                                                                             |  |                                                                                                                                                                  |                                                                  |                                                                                                 |                              |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Ram Lal Mittal</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             |  | DEGREE <b>M.D.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                  |                                                                                                 |                              | 22c. DATE SIGNED<br><b>5/25/86</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAM LAL MITTAL</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             |  | 22e. ADDRESS<br><b>5601 LOCH RAVEN BLVD.<br/>GOOD SAMARITAN HOSPITAL, BALTIMORE, MD</b>                                                                          |                                                                  |                                                                                                 |                              |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>May 28 1986</b>                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem.</b>                                                                                                 |                                                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Maryland</b>                      |                              |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 26 1986</b>                                                                                                              |                                                                  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                |                              |                                                                                                                            |  |

Leonard J. Roe, Inc. Baltimore, Maryland  
Serial No. 28 1965 Bulsey Valley Res. Cockeysville Maryland

21-00-2001 Samuel A. Valerius 3032 Westfield Drive.

Yorba Yonkers

Bellevue x

3032 Westfield Dr. 3032

Honolulu

U.S.A.

x

Bellevue

Bellevue

Bellevue

21-00-2001

00-07398

item 14, film#G615-

FOR 5-23-86jlb  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 2 4 3

|                                                                                                                                                                                                                                                                                                                                                                  |                                                                                  |                                                                                                                                                          |                                                                                      |                                                                                      |                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Hedwig T. (IDA) Valenti</b>                                                                                                                                                                                                                                                                       |                                                                                  |                                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-21-86</b>                                |                                                                                      | 2b. HOUR<br><b>7:20 AM</b>                                     |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                          | 4. RACE<br><b>W</b>                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7/19/18</b>                                                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>                                         |                                                                                      | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.                  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>—</b>                                         | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |                                                                                      |                                                                |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Mercy Hospital</b> |                                                                                                                                                          | 11a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |                                                                                      | 12. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>                   |
| 11a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Md.</b>                                                                                                                                                                                                                                                       |                                                                                  | 11b. COUNTY<br><b>—</b>                                                                                                                                  | 11c. CITY OR TOWN<br><b>Baltimore</b>                                                | 13. STREET ADDRESS / ZIP CODE<br><b>1353 Andre St. 91230</b>                         |                                                                |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stephen Lonczynski</b>                                                                                                                                                                                                                                                                                              |                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia Gosiorowski</b>                                                                                |                                                                                      |                                                                                      |                                                                |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATE)<br><b>No</b>                                                                                                                                                                                                                                                                           |                                                                                  | 17. SOCIAL SECURITY NO.<br><b>215-01-1348A</b>                                                                                                           |                                                                                      | 18. INFORMANT ADDRESS<br><b>Louis Valenti 1353 Andre St. 91230</b>                   |                                                                |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>exacerbation of COPD 2° morbid obesity</b>                                                                                                                                                                                     |                                                                                  |                                                                                                                                                          |                                                                                      |                                                                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Yrs.</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____                                                                                                                                                                                                                                                                                                                      |                                                                                  |                                                                                                                                                          |                                                                                      |                                                                                      |                                                                |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                                                                                                                                                                                                                                      |                                                                                  |                                                                                                                                                          |                                                                                      |                                                                                      |                                                                |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>Bacterial sepsis</b>                                                                                                                                                                                                       |                                                                                  |                                                                                                                                                          |                                                                                      |                                                                                      |                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          |                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                             |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)       |                                                                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                   |                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-25</b> , 19 <b>86</b> , to <b>5-21</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5-21</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                  |                                                                                                                                                          |                                                                                      |                                                                                      |                                                                |
| 22b. SIGNATURE<br><b>Kimberly A. Brandecker, MD</b>                                                                                                                                                                                                                                                                                                              |                                                                                  |                                                                                                                                                          |                                                                                      | 22c. DATE SIGNED<br><b>5-21-86</b>                                                   |                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alan Reisinger, M.D.</b>                                                                                                                                                                                                                                                                                             |                                                                                  |                                                                                                                                                          |                                                                                      | 22e. ADDRESS                                                                         |                                                                |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                      |                                                                                  | 23b. DATE<br><b>5/24/86</b>                                                                                                                              |                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer</b>                      |                                                                |
| 23d. LOCATION<br>CITY OR TOWN<br><b>4430 Blue Ridge Rd. Mt. Airy, Md.</b>                                                                                                                                                                                                                                                                                        |                                                                                  | 23e. DATE REC'D. BY REGISTRAR<br><b>MAY 22 1986</b>                                                                                                      |                                                                                      |                                                                                      |                                                                |
| 23f. REGISTRAR'S SIGNATURE<br><b>Charles E. Stevens</b>                                                                                                                                                                                                                                                                                                          |                                                                                  |                                                                                                                                                          |                                                                                      |                                                                                      |                                                                |

MEDICAL CERTIFICATION

BP

100-100000

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100-100000

00-07664

Items #14, 15 G 610 6/5/86

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 14244  
REG. NO.FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                 |                                                            |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BHN J. VALIS                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5/22/86                         |                                                                                                                                                             |                                                                                | 2b. HOUR<br>5:46 A.M.                                                                           |                                                            |                                                                                                                            |  |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br>C                                                                                                                       |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12/8/07                                                                                                               |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.                                                      |                                                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                             |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |                                                            |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SO. BALTIMORE GEN HSP |                                                                        |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br>RETIRED                     |                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>MD                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |                                                                        | 13c. COUNTY<br>BALTIMORE                                                                                                                                    |                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                            | 13e. STREET ADDRESS / ZIP CODE<br>1213 LIGHT ST. 21230                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John VALIS                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Barbara VoJik         |                                                                                                                                                             |                                                                                | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                      |                                                            |                                                                                                                            |  |
| 16b. SOCIAL SECURITY NO.<br>213 64 6735                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    | 17. INFORMANT<br>ADDRESS<br>MEDICAL CHART                              |                                                                                                                                                             |                                                                                |                                                                                                 |                                                            |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) PROBABLE CARDIAC <del>thrombosis</del> DYSRHYTHMIA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                 |                                                            |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                              |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                 |                                                            |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                          |  |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                                 |                                                            |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                         |  |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                 |                                                            |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 22 May 1986, to 22 May 1986, that (I) (we) last saw the deceased alive on 22 May 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                  |  |                                                                                                                                    |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                 |                                                            |                                                                                                                            |  |
| 22b. SIGNATURE<br>Joe B. Corn M.D.                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    | 22c. DATE SIGNED<br>22 May 86                                          |                                                                                                                                                             |                                                                                | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOE B. CORN                                            |                                                            |                                                                                                                            |  |
| 22e. ADDRESS<br>3001 S. Hanover                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    | 22f. CITY OR TOWN<br>BACON. MD. 21230                                  |                                                                                                                                                             |                                                                                |                                                                                                 |                                                            |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    | 23b. DATE<br>5-24-1986                                                 |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY REDEEMER                            |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>RAYMOND L. KACZOROWSKI                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    | 24b. ADDRESS<br>2525 FLEET ST.                                         |                                                                                                                                                             |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br>MAY 27 1986                                                    |                                                            | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Henderson                                                                      |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



1. The first part of the report is a general description of the area. It is a small, isolated area, and the only access is by a narrow path. The area is surrounded by a dense forest, and the only buildings are a few small huts. The population is very small, and the people are very poor. They live in a very primitive way, and they have no modern amenities. The only source of food is the forest, and they have to hunt and gather for their food. They have no money, and they have to barter for the things they need. The area is very remote, and it is very difficult to reach. There are no roads, and the only way to get there is by a narrow path. The area is very beautiful, but it is also very dangerous. There are many snakes and other dangerous animals in the forest. The people are very brave, but they are also very superstitious. They believe in many different gods and spirits, and they have many different rituals. They are very proud of their culture, and they want to preserve it. They are very friendly to the visitors, but they are also very suspicious. They do not like strangers, and they are always watching them. They are very curious about the visitors, and they want to know everything about them. They are very interested in the visitors' clothes and their weapons. They are very impressed by the visitors' technology, and they want to see more of it. They are very happy to see the visitors, and they are always welcoming them. They are very kind and hospitable, and they always offer the visitors food and shelter. They are very grateful for the visitors' help, and they are always trying to do something for them. They are very loyal to their community, and they are always helping each other. They are very brave and strong, and they are always ready to defend their land. They are very proud of their land, and they are always trying to improve it. They are very hardworking, and they are always trying to make a better life for themselves. They are very resilient, and they are always able to overcome their difficulties. They are very optimistic, and they are always looking for the good in every situation. They are very happy and content, and they are always enjoying their life. They are very peaceful, and they are always getting along with each other. They are very loving, and they are always caring for each other. They are very kind, and they are always helping others. They are very generous, and they are always sharing their food and their resources. They are very honest, and they are always telling the truth. They are very trustworthy, and they are always keeping their promises. They are very reliable, and they are always doing what they say. They are very responsible, and they are always taking care of their duties. They are very disciplined, and they are always following the rules. They are very organized, and they are always keeping things in order. They are very clean, and they are always keeping their homes and their surroundings clean. They are very healthy, and they are always taking care of their bodies. They are very strong, and they are always able to do hard work. They are very brave, and they are always willing to face danger. They are very confident, and they are always believing in themselves. They are very happy, and they are always smiling. They are very kind, and they are always being nice to everyone. They are very generous, and they are always sharing their food and their resources. They are very honest, and they are always telling the truth. They are very trustworthy, and they are always keeping their promises. They are very reliable, and they are always doing what they say. They are very responsible, and they are always taking care of their duties. They are very disciplined, and they are always following the rules. They are very organized, and they are always keeping things in order. They are very clean, and they are always keeping their homes and their surroundings clean. They are very healthy, and they are always taking care of their bodies. They are very strong, and they are always able to do hard work. They are very brave, and they are always willing to face danger. They are very confident, and they are always believing in themselves. They are very happy, and they are always smiling. They are very kind, and they are always being nice to everyone.

2. The second part of the report is a description of the people. They are a very primitive people, and they live in a very primitive way. They have no modern amenities, and they have to live with what they have. They are very poor, and they have to struggle to survive. They are very hardworking, and they are always trying to make a better life for themselves. They are very resilient, and they are always able to overcome their difficulties. They are very optimistic, and they are always looking for the good in every situation. They are very happy and content, and they are always enjoying their life. They are very peaceful, and they are always getting along with each other. They are very loving, and they are always caring for each other. They are very kind, and they are always helping others. They are very generous, and they are always sharing their food and their resources. They are very honest, and they are always telling the truth. They are very trustworthy, and they are always keeping their promises. They are very reliable, and they are always doing what they say. They are very responsible, and they are always taking care of their duties. They are very disciplined, and they are always following the rules. They are very organized, and they are always keeping things in order. They are very clean, and they are always keeping their homes and their surroundings clean. They are very healthy, and they are always taking care of their bodies. They are very strong, and they are always able to do hard work. They are very brave, and they are always willing to face danger. They are very confident, and they are always believing in themselves. They are very happy, and they are always smiling. They are very kind, and they are always being nice to everyone. They are very generous, and they are always sharing their food and their resources. They are very honest, and they are always telling the truth. They are very trustworthy, and they are always keeping their promises. They are very reliable, and they are always doing what they say. They are very responsible, and they are always taking care of their duties. They are very disciplined, and they are always following the rules. They are very organized, and they are always keeping things in order. They are very clean, and they are always keeping their homes and their surroundings clean. They are very healthy, and they are always taking care of their bodies. They are very strong, and they are always able to do hard work. They are very brave, and they are always willing to face danger. They are very confident, and they are always believing in themselves. They are very happy, and they are always smiling. They are very kind, and they are always being nice to everyone.

3. The third part of the report is a description of the flora and fauna. The area is very rich in biodiversity, and there are many different plants and animals. There are many different types of trees, and there are many different types of fruits. There are many different types of birds, and there are many different types of insects. There are many different types of snakes, and there are many different types of other animals. The area is very beautiful, and it is very interesting to see all the different plants and animals. The people are very knowledgeable about the plants and animals, and they are always using them for food and medicine. They are very careful not to harm the plants and animals, and they are always trying to preserve them. They are very respectful of the land, and they are always treating it with care. They are very grateful for the land, and they are always trying to do something for it. They are very happy and content, and they are always enjoying their life. They are very peaceful, and they are always getting along with each other. They are very loving, and they are always caring for each other. They are very kind, and they are always helping others. They are very generous, and they are always sharing their food and their resources. They are very honest, and they are always telling the truth. They are very trustworthy, and they are always keeping their promises. They are very reliable, and they are always doing what they say. They are very responsible, and they are always taking care of their duties. They are very disciplined, and they are always following the rules. They are very organized, and they are always keeping things in order. They are very clean, and they are always keeping their homes and their surroundings clean. They are very healthy, and they are always taking care of their bodies. They are very strong, and they are always able to do hard work. They are very brave, and they are always willing to face danger. They are very confident, and they are always believing in themselves. They are very happy, and they are always smiling. They are very kind, and they are always being nice to everyone. They are very generous, and they are always sharing their food and their resources. They are very honest, and they are always telling the truth. They are very trustworthy, and they are always keeping their promises. They are very reliable, and they are always doing what they say. They are very responsible, and they are always taking care of their duties. They are very disciplined, and they are always following the rules. They are very organized, and they are always keeping things in order. They are very clean, and they are always keeping their homes and their surroundings clean. They are very healthy, and they are always taking care of their bodies. They are very strong, and they are always able to do hard work. They are very brave, and they are always willing to face danger. They are very confident, and they are always believing in themselves. They are very happy, and they are always smiling. They are very kind, and they are always being nice to everyone.

4. The fourth part of the report is a description of the climate. The area has a very hot and dry climate, and it is very difficult to live in. There are very few rains, and the people have to get their water from the forest. They are very careful not to waste water, and they are always trying to conserve it. They are very resilient, and they are always able to overcome their difficulties. They are very optimistic, and they are always looking for the good in every situation. They are very happy and content, and they are always enjoying their life. They are very peaceful, and they are always getting along with each other. They are very loving, and they are always caring for each other. They are very kind, and they are always helping others. They are very generous, and they are always sharing their food and their resources. They are very honest, and they are always telling the truth. They are very trustworthy, and they are always keeping their promises. They are very reliable, and they are always doing what they say. They are very responsible, and they are always taking care of their duties. They are very disciplined, and they are always following the rules. They are very organized, and they are always keeping things in order. They are very clean, and they are always keeping their homes and their surroundings clean. They are very healthy, and they are always taking care of their bodies. They are very strong, and they are always able to do hard work. They are very brave, and they are always willing to face danger. They are very confident, and they are always believing in themselves. They are very happy, and they are always smiling. They are very kind, and they are always being nice to everyone. They are very generous, and they are always sharing their food and their resources. They are very honest, and they are always telling the truth. They are very trustworthy, and they are always keeping their promises. They are very reliable, and they are always doing what they say. They are very responsible, and they are always taking care of their duties. They are very disciplined, and they are always following the rules. They are very organized, and they are always keeping things in order. They are very clean, and they are always keeping their homes and their surroundings clean. They are very healthy, and they are always taking care of their bodies. They are very strong, and they are always able to do hard work. They are very brave, and they are always willing to face danger. They are very confident, and they are always believing in themselves. They are very happy, and they are always smiling. They are very kind, and they are always being nice to everyone.

11/10/11

0-07204

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  |                                                                                                                                                             |                                                                |                                                                                      |                                |                                                                                                                                            |                                                                                                 | REG. NO. 86 14245 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CORNELIA B. VANN                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 17 86                 |                                                                                      |                                | 2b. HOUR<br>12 PM                                                                                                                          |                                                                                                 |                   |  |
| 3. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>B                                                                                              |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 24 32                                                                                                              |                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53 YRS.                                           |                                | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                               |                                                                                                 |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, CITY MD.                          |                                |                                                                                                                                            |                                                                                                 |                   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                             |                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                                | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                          |                                                                                                 |                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                           |  |                                                                                                                                                             | 13b. COUNTY                                                    |                                                                                      | 13c. CITY OR TOWN<br>BALTIMORE |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAMUEL PRIDGEN                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HATTIE HARRIS |                                                                                      |                                |                                                                                                                                            |                                                                                                 |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>227325856                                      |  | 17. INFORMANT ADDRESS<br>KENNETH PRIDGEN 4719 ALHAMBRA AVE. 21212                                                                                           |                                                                |                                                                                      |                                |                                                                                                                                            |                                                                                                 |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic carcinoma of the breast</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>carcinoma of the breast</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 yrs 2 mo</u><br><u>5 years</u> |  |                                                                                                           |  |                                                                                                                                                             |                                                                |                                                                                      |                                |                                                                                                                                            |                                                                                                 |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>none</u>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  |                                                                                                                                                             |                                                                |                                                                                      |                                |                                                                                                                                            |                                                                                                 |                   |  |
| 19a. DATE OF OPERATION<br><u>n/a</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  |                                                                                                                                                             |                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                                                                                                 |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |                                                                |                                                                                      |                                |                                                                                                                                            |                                                                                                 |                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                |                                                                                      |                                |                                                                                                                                            |                                                                                                 |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/30</u> , 19 <u>84</u> , to <u>5/17</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/13</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                                                                                                                                                 |  |                                                                                                           |  |                                                                                                                                                             |                                                                |                                                                                      |                                |                                                                                                                                            |                                                                                                 |                   |  |
| 22b. SIGNATURE<br><u>Victor R. Risch MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | DEGREE<br>MD                                                                                              |  | 22c. DATE SIGNED<br>5/20/86                                                                                                                                 |                                                                |                                                                                      |                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Victor R. Risch MD                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS<br>The Johns Hopkins Oncology Center<br>600 N. Wolfe St Baltimore MD                         |  |                                                                                                                                                             |                                                                |                                                                                      |                                |                                                                                                                                            |                                                                                                 |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>5-23-86                                                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PLEASANT SHADE CEM.                                                                                                   |                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>NEWPORT NEWS VIRGINIA                  |                                |                                                                                                                                            |                                                                                                 |                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WM.C.MARCH F/H INC. 1101 EAST NORTH AVENUE                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 21 1986                                                                                                                |                                                                | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                     |                                |                                                                                                                                            |                                                                                                 |                   |  |

BP

40373-0



00-07417

DIVISION OF VITAL RECORDS, 201 W. PRISTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 10 DAYS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRISTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14246

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Angela Vaughn                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                              | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>5 20 19 86                                                                                                  |                                                                                                 | 2b. HOUR<br>M<br>10:36                       |
| 3. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                                              | 4. RACE<br>N.                                                                                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 6 1960                                                                                                              | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>85 YRS.                                                   | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md                                                                                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?<br>U.O.A.                                                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Apt 204 1300 E. Lanvale Street | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |                                              |
| 13a. STATE<br>Md                                                                                                                                                                                                                                                                                                                                                                                                                         | 13b. CITY OR TOWN<br>Baltimore                                                                                                               | 13c. STREET ADDRESS<br>1300 E. Lanvale St                                                                                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 14. FATHER'S NAME<br>George Winder                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>Ada                                                                                                                             |                                                                                                 |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                              | 16b. SOCIAL SECURITY NO.                                                                                                                     | 17. INFORMANT ADDRESS<br>Rev. Carl Fisher 1501 E. Oliver St                                                                                                 |                                                                                                 |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                   |                                                                                                                                              |                                                                                                                                                             |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                       |                                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                            |                                                                                                                                                             | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                                                 |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                                                  |                                                                                                 |                                              |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                              |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                                                                                     | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER                                                                                                |                                                                                                                                                             | DATE SIGNED<br>5/21/86                                                                          |                                              |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Gregory R. Kauffman, M.D.                                                                                                                                                                                                                                                                                                                                                                             | ADDRESS<br>111 Penn Street, Balto., MD 21201                                                                                                 |                                                                                                                                                             |                                                                                                 |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                      | 23b. DATE<br>5/27/86                                                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary                                                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>A.D. County Md                                    |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Locks Funeral Home                                                                                                                                                                                                                                                                                                                                                                                       | ADDRESS<br>13047                                                                                                                             | DATE REC'D. BY REGISTRAR<br>MAY 23 1986                                                                                                                     | 25b. REGISTRAR'S SIGNATURE<br>James Davidson Handell                                            |                                              |

07/B4  
25MBP  
DHMH - 17  
(VR A15 ME (5))

11-11-00

UNCLASSIFIED

UNCLASSIFIED

SECRET NOTICE

00-08969

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 4 7

REG. NO.

|                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                 |                                                                                                                                                             |                                                                                |                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>Geoffrey</u> MIDDLE <u>Marvin</u> LAST <u>Veale, Jr.</u>                                                                                                                                                                                                                                     |                                                                                                                                 | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>5</u> <u>31</u> '86                                                                                                  |                                                                                | 2b. HOUR<br><u>4:10 AM</u>                                                               |
| 3. SEX<br><u>M</u>                                                                                                                                                                                                                                                                                                                           | 4. RACE<br><u>N</u> Black                                                                                                       | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>5</u> <u>31</u> '86                                                                                                   |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS <u>3</u> MONTHS <u>18</u>                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MD.</u>                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                        |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Mercy Hosp.</u> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>N/A</u> | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>N/A</u>                                          |
| 13a. STATE<br><u>MD.</u>                                                                                                                                                                                                                                                                                                                     |                                                                                                                                 | 13b. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                       | 13c. STREET ADDRESS / ZIP CODE<br><u>6620 Pioneer Drive</u> <u>21214</u>       |                                                                                          |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><u>Geoffrey Marvin Veale</u>                                                                                                                                                                                                                                                                          |                                                                                                                                 | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>Verna Lisa Maria Robinson</u>                                                                              |                                                                                |                                                                                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>                                                                                                                                                                                                                                                            |                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br><u>—</u>                                                                                                                        |                                                                                | 17. INFORMANT ADDRESS<br><u>6620 PIONEER DR D</u><br><u>LGSA ROBINSON VEALE BALTO MD</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>IMMATUREITY</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                 |                                                                                                                                                             |                                                                                |                                                                                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                           |                                                                                                                                 |                                                                                                                                                             |                                                                                |                                                                                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                       |                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                     |                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)           |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                 |                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                        |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) visit the body after death.                 |                                                                                                                                 |                                                                                                                                                             |                                                                                |                                                                                          |
| 22b. SIGNATURE<br><u>George W. Tittle, M.D.</u>                                                                                                                                                                                                                                                                                              |                                                                                                                                 | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                | 22c. DATE SIGNED<br><u>5/31/86</u>                                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                        |                                                                                                                                 | 22e. ADDRESS                                                                                                                                                |                                                                                |                                                                                          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>                                                                                                                                                                                                                                                                                | 23b. DATE<br><u>6-2-86</u>                                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><u>FAIRVIEW CEM</u>                                                                                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>FOREST HILL MD</u>            |                                                                                          |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>GEORGE W TITTLE</u>                                                                                                                                                                                                                                                                                       |                                                                                                                                 | ADDRESS<br><u>JARROVILL MD</u>                                                                                                                              |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 10 1986</u>                                      |
|                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>                                                                                                 |                                                                                |                                                                                          |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this portion of the certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_





00-07129

9 227 19 04  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
VENDE, SALVATORE  
01/01/88

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remember to attach page 3 to the death certificate. Pages found 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other final disposition of the body, the medical examiner's certificate must be attached at the bottom of this certificate.

DHMH - 16 60M 7/84  
(VIA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                              |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>SALVATORE - VERDE                                                                                                                                                                                                                                             |  |                                                                                                                                      |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>MAY 17, 1986                                                                                           |  | 2b. HOUR<br>11:00pm                                                                                                        |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br>White                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>January 1, 1922                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>64                                                                                                 |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Ponza, Italy                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                                 |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Net. Restaurant                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Owner                                                                                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                             |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 13a. STATE<br>Conn.                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY<br>New Haven                                                                                                             |  | 13c. CITY OR TOWN<br>Wallingford                                                                                                                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |  | 13e. STREET ADDRESS / ZIP CODE<br>16 Fawn Drive 06492                                                                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Francesco Verde                                                                                                                                                                                                                                                              |  |                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Civita DeLuca                                                                                                 |  |                                                                                                                                            |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>088-22-4486                                                                  |  | 17. INFORMANT ADDRESS<br>Warren Funeral Home 386 Main Street                                                                                                |  |                                                                                                                                            |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral Anoxia<br>DUE TO, OR AS A CONSEQUENCE OF (b) Cardiopulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF (c) exsanguination from massive upper gastro-intestinal hemorrhage. |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5-15 minutes<br>15 minutes<br>7 hours                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Hepatocellular Carcinoma                                                                                                                                                        |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                                            |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22a. I certify that (I) this hospital attended the deceased from 5/17/1986 to 5/17/1986, that (I/we) most saw the deceased alive on 5/17/1986, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.                 |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Shanta Purcell                                                                                                                                                                                                                                                                                    |  |                                                                                                                                      |  | DEGREE<br>MD                                                                                                                                                |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>5/17/1986                                                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Shanta Purcell                                                                                                                                                                                                                                                             |  |                                                                                                                                      |  | 22e. ADDRESS<br>600 N WOLFE ST BALTIMORE, MD 21205<br>THE JOHNS HOPKINS HOSPITAL                                                                            |  |                                                                                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                 |  | 23b. DATE<br>May 21, 1986                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. John's                                                                                                            |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Wallingford New Haven Conn.                                                                     |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>MAY 20 1986 Julia Davidson-Rodriguez                           |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck Inc. Baltimore, Maryland                                                                                                                                                                                                                                                    |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |

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July 21, 1950 - St. John's

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Edward J. Koch, Inc., Baltimore, Maryland



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 5 0

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                 |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Rose BELL Vinson                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                 |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 8, 1986                                              |                                                                                      | 2b. HOUR<br>M                                                                                                              |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                               | 4. RACE<br>Black                                                                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 11 24                                                                                                               |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>GA.                                                                                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                          |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1732 Darley Avenue |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A                         | 12b. KIND OF BUSINESS OR INDUSTRY                                                    |                                                                                                                            |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                         | 13b. COUNTY                                                                                                                     | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>1732 DARLEY AVE. 21213                             |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LEMUEL HUNTER                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LULA ELIZATH LAWTON                                                                                        |                                                                                                 |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br>212421127                                                                                                                       | 17. INFORMANT<br>ADDRESS<br>LUCILLE VINSON 1732 DARLEY AVE.                                     |                                                                                      |                                                                                                                            |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>MINUTES</u> |                                                                                                                                 |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>MASSIVE CEREBRAL VASCULAR ACCIDENT</u>                                                                                                                                                                                                                                              |                                                                                                                                 |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                           |                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                  |                                                                                      |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                   |                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                      |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY</u> , 19 <u>85</u> , to <u>PRESENT</u> , 19 <u>86</u> , that (II) (we) lost saw the deceased alive on <u>9 APRIL</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                     |                                                                                                                                 |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br><u>Dolores M. Purnell MD</u>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                 | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                                 | 22c. DATE SIGNED<br><u>8 MAY 1986</u>                                                |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DOLORES M. PURNELL MD</u>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                 | 22e. ADDRESS<br><u>JOHN HOPKINS HEALTH PLAN<br/>1000 E. EAGER ST.<br/>BALTIMORE, MD 21202</u>                                                               |                                                                                                 |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                      | 23b. DATE<br>5-14-86                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE                                                                                                             |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                     |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>March Funeral Homes 1101 East North Ave.                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                 |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>MAY 13 1986                                                    |                                                                                      |                                                                                                                            |

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20X FOLLOW UP





00-07282

DIVISION OF VITAL RECORDS, 301 N. FREEDOM ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 N. FREEDOM STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
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(VR A15 ME (5))  
15M/7/77

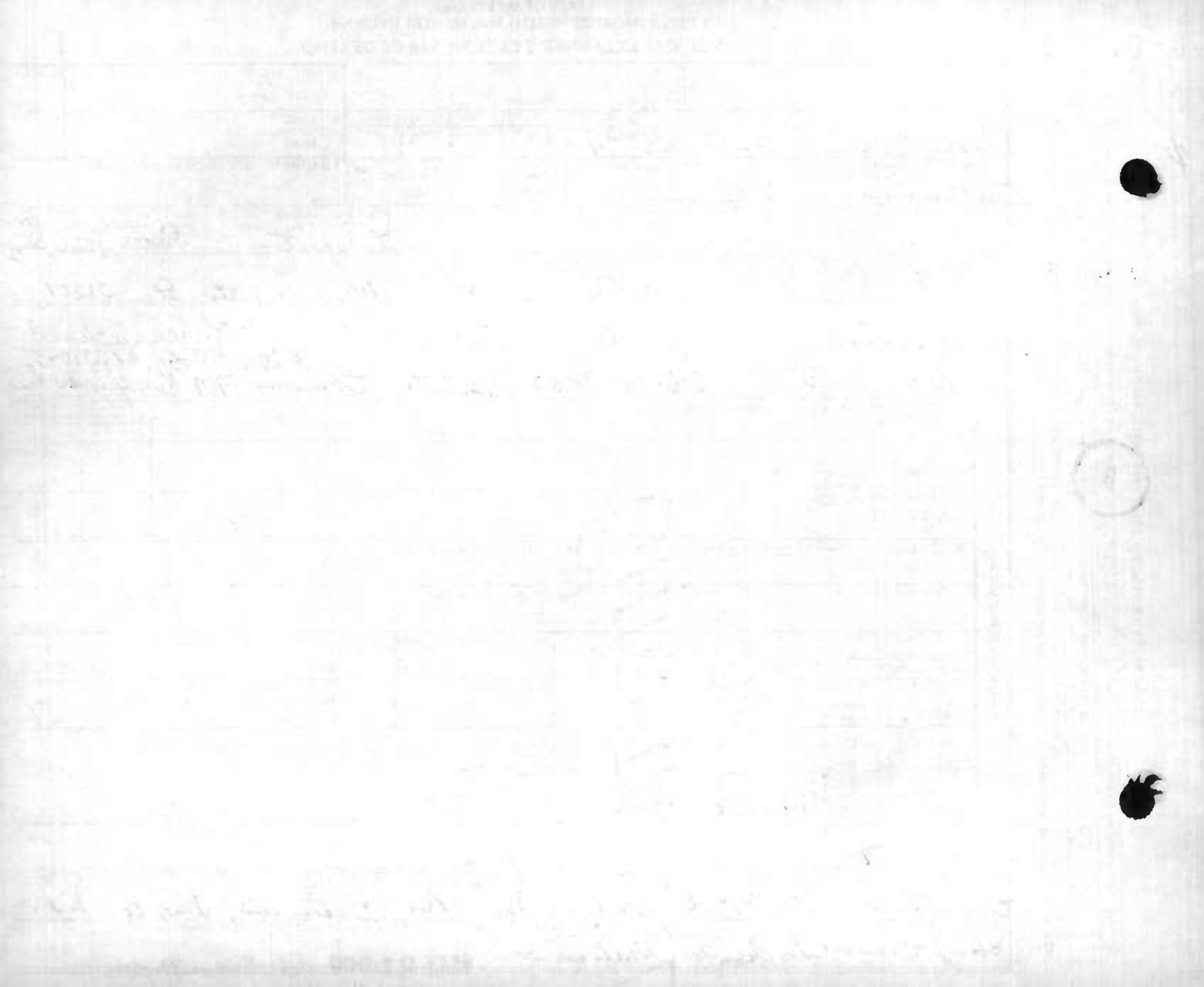
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4251

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                 |  |                                                                                                                                                          |  |                                                                                              |  |                                                |  |               |  |                                                                         |  |                                         |  |                                                     |  |                             |  |                                                                                  |  |                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|------------------------------------------------|--|---------------|--|-------------------------------------------------------------------------|--|-----------------------------------------|--|-----------------------------------------------------|--|-----------------------------|--|----------------------------------------------------------------------------------|--|----------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5-12-86 <sub>19</sub>                                |  |                                                                                                                                                          |  |                                                                                              |  |                                                |  |               |  | 2b. HOUR M 10A                                                          |  |                                         |  |                                                     |  |                             |  |                                                                                  |  |                |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                       |  | FIRST Paul                                                                                                                      |  | MIDDLE                                                                                                                                                   |  | LAST Virkutis                                                                                |  | 3. SEX Male                                    |  | 4. RACE White |  | 5. DATE OF BIRTH MONTH DAY YEAR 3-5-1912                                |  | 6. AGE (IN YEARS) LAST BIRTHDAY 74 YRS. |  | IF UNDER 1 YR. MONTHS DAYS                          |  | IF UNDER 24 HRS. HOURS MIN. |  | 7c. DATE PRONOUNCED DEAD 5-12-86 <sub>19</sub>                                   |  | 7d. HOUR 3:10A |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lithuania                                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY? Lithuania                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                                      |  |                                                |  |               |  |                                                                         |  |                                         |  |                                                     |  |                             |  |                                                                                  |  |                |  |
| 10. CITY OR TOWN OF DEATH Baltimore                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Seton Manor Nursing Hm. |  |                                                                                                                                                          |  |                                                                                              |  |                                                |  |               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter |  |                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY Eastern Star Bldg |  |                             |  |                                                                                  |  |                |  |
| 13a. STATE Md                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY                                                                                                                     |  | 13c. CITY OR TOWN Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 116 S. Poppleton St. 21201 |  |               |  |                                                                         |  |                                         |  |                                                     |  |                             |  |                                                                                  |  |                |  |
| 14. FATHER'S NAME FIRST Antonio                                                                                                                                                                                                                                                                                                                                                                                                        |  | MIDDLE                                                                                                                          |  | LAST Virkutis                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME FIRST Marie                                                         |  | MIDDLE Kacerauskas                             |  | LAST          |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No    |  |                                         |  |                                                     |  |                             |  |                                                                                  |  |                |  |
| 16a. (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO. 216-40-3132                                                                                            |  | 17. INFORMANT Kestutis Chesnow 9909 Windflower Dr. Baltimore City, Md. 21043                                                                             |  |                                                                                              |  |                                                |  |               |  |                                                                         |  |                                         |  |                                                     |  |                             |  |                                                                                  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hanging<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                             |  |                                                                                                                                 |  |                                                                                                                                                          |  |                                                                                              |  |                                                |  |               |  |                                                                         |  |                                         |  |                                                     |  |                             |  |                                                                                  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |  |                                                                                                                                                          |  |                                                                                              |  |                                                |  |               |  |                                                                         |  |                                         |  |                                                     |  |                             |  |                                                                                  |  |                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                               |  |                                                                                                                                                          |  |                                                                                              |  |                                                |  |               |  |                                                                         |  |                                         |  |                                                     |  |                             |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2P.M. 5-12-86                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject hanged self                                                        |  |                                                                                              |  |                                                |  |               |  |                                                                         |  |                                         |  |                                                     |  |                             |  |                                                                                  |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) BATHRM. AREA                                                        |  | 21f. LOCATION STREET 501 W. Franklin Street CITY OR TOWN Baltimore, Maryland                                                                             |  |                                                                                              |  |                                                |  |               |  |                                                                         |  |                                         |  |                                                     |  |                             |  |                                                                                  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                 |  |                                                                                                                                                          |  |                                                                                              |  |                                                |  |               |  |                                                                         |  |                                         |  |                                                     |  |                             |  |                                                                                  |  |                |  |
| ACTUAL SIGNATURE Margaret A. Yhell                                                                                                                                                                                                                                                                                                                                                                                                     |  | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER                                                                                 |  |                                                                                                                                                          |  |                                                                                              |  |                                                |  |               |  |                                                                         |  |                                         |  |                                                     |  |                             |  | DATE SIGNED 5-12-86                                                              |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                              |  | ADDRESS 111 Penn Street                                                                                                         |  |                                                                                                                                                          |  |                                                                                              |  |                                                |  |               |  |                                                                         |  |                                         |  |                                                     |  |                             |  |                                                                                  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation                                                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE 5-17-1986                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park                                                                                                    |  | 23d. LOCATION CITY OR TOWN Catonsville, Maryland COUNTY Baltimore Co. STATE Md.              |  |                                                |  |               |  |                                                                         |  |                                         |  |                                                     |  |                             |  |                                                                                  |  |                |  |
| 24. FUNERAL DIRECTOR NAME John J. Connor                                                                                                                                                                                                                                                                                                                                                                                               |  | ADDRESS 1001 E. 90th St. Baltimore, Md. 21223                                                                                   |  | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE                                                                                                  |  |                                                                                              |  |                                                |  |               |  |                                                                         |  |                                         |  |                                                     |  |                             |  |                                                                                  |  |                |  |

MAY 21 1986





00-07325

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 5 2  
REG. NO.

|                                                                                                                                                                                                                                                                                                |                                                                                                                                            |                                                                                |                                                                |                                   |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                         |                                                                                                                                            | 2a. DATE OF DEATH                                                              |                                                                | 2b. HOUR                          |                                              |
| DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                  |                                                                                                                                            | MONTH DAY YEAR                                                                 |                                                                | M                                 |                                              |
| Joseph J. (W.) Vitek (Powell)                                                                                                                                                                                                                                                                  |                                                                                                                                            | May 19, 1986                                                                   |                                                                |                                   |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                         | 4. RACE                                                                                                                                    | 5. DATE OF BIRTH                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)                                | IF UNDER 1 YEAR                   |                                              |
| Male                                                                                                                                                                                                                                                                                           | White                                                                                                                                      | MONTH DAY YEAR                                                                 | 66                                                             | IF UNDER 72 HRS                   |                                              |
|                                                                                                                                                                                                                                                                                                |                                                                                                                                            |                                                                                |                                                                | MONTHS                            | DAYS                                         |
|                                                                                                                                                                                                                                                                                                |                                                                                                                                            |                                                                                |                                                                | HOURS                             | MIN.                                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                                                |                                   |                                              |
| Md.                                                                                                                                                                                                                                                                                            | USA                                                                                                                                        | Baltimore (city) MD                                                            |                                                                |                                   |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |                                                                | 12b. KIND OF BUSINESS OR INDUSTRY |                                              |
| Baltimore                                                                                                                                                                                                                                                                                      | 2229 E. Pratt Street                                                                                                                       | Weighman                                                                       |                                                                | Railroad                          |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                     | 13b. COUNTY                                                                                                                                | 13c. INSIDE CITY LIMITS?                                                       | 13d. STREET ADDRESS / ZIP CODE                                 |                                   |                                              |
| Md.                                                                                                                                                                                                                                                                                            | Baltimore                                                                                                                                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 2229 E. Pratt Street 21231                                     |                                   |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                              | 15. MOTHER'S MAIDEN NAME                                                                                                                   |                                                                                |                                                                |                                   |                                              |
| John Vitek                                                                                                                                                                                                                                                                                     | Marie Schirmer                                                                                                                             |                                                                                |                                                                |                                   |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                              | 16b. SOCIAL SECURITY NO.                                                                                                                   | 17. INFORMANT ADDRESS                                                          |                                                                |                                   |                                              |
| Yes                                                                                                                                                                                                                                                                                            | 220-07-1327                                                                                                                                | George C. Powell Sr. 1839 Darrich Dr. 21234                                    |                                                                |                                   |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)                                                                                                                                                                       |                                                                                                                                            |                                                                                |                                                                |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| HYPERTENSIVE CARDIO-VASC DISEASE                                                                                                                                                                                                                                                               |                                                                                                                                            |                                                                                |                                                                |                                   | 8 years                                      |
| DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                                                                                                                                                                             |                                                                                                                                            |                                                                                |                                                                |                                   |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                             |                                                                                                                                            |                                                                                |                                                                |                                   |                                              |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: GOUT, HYPERLIPIDEMIA                                                                                                                                          |                                                                                                                                            |                                                                                |                                                                |                                   |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           | 20a. AUTOPSY?                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |                                              |
|                                                                                                                                                                                                                                                                                                |                                                                                                                                            | YES <input type="checkbox"/> NO <input type="checkbox"/>                       | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |                                              |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                               | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                |                                   |                                              |
|                                                                                                                                                                                                                                                                                                | P.M. 19                                                                                                                                    |                                                                                |                                                                |                                   |                                              |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                           | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        | 21f. LOCATION                                                                  |                                                                |                                   |                                              |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                              |                                                                                                                                            | CITY OR TOWN COUNTY STATE                                                      |                                                                |                                   |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/1/86 to 5/19/86 that (I) (we) last saw the deceased alive on 5/13/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |                                                                                                                                            |                                                                                |                                                                |                                   |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                 | DEGREE                                                                                                                                     | 22c. DATE SIGNED                                                               |                                                                |                                   |                                              |
| Dr. B. Kaplan MD                                                                                                                                                                                                                                                                               | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 5/21/86                                                                        |                                                                |                                   |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                          | 22e. ADDRESS                                                                                                                               |                                                                                |                                                                |                                   |                                              |
| Dr. B. Kaplan MD                                                                                                                                                                                                                                                                               | 129 S Broadway                                                                                                                             | 21231                                                                          |                                                                |                                   |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                      | 23b. DATE                                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY                                             | 23d. LOCATION                                                  | 23e. COUNTY STATE                 |                                              |
| Burial                                                                                                                                                                                                                                                                                         | 5-24-1986                                                                                                                                  | Lorraine Park                                                                  | Baltimore                                                      | Md.                               |                                              |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                           | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |                                                                                | 25b. REGISTRAR'S SIGNATURE                                     |                                   |                                              |
| John M. Weber & Sons Inc. 401 S. Chester St.                                                                                                                                                                                                                                                   | MAY 22 1986                                                                                                                                |                                                                                | John M. Weber & Sons Inc.                                      |                                   |                                              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



47



ET

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - T6 50M 1/8"  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal investigation is required. ADVISE

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                               |  |                    |  |                     |  |       |  |          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|-------------------------------|--|--------------------|--|---------------------|--|-------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                      |  | FIRST                                                                                                     |  | MIDDLE                                                                                                                                                      |  | LAST                                                                |  | 2a. DATE OF DEATH             |  | MONTH              |  | DAY                 |  | YEAR  |  | 2b. HOUR |  |
| EILEN                                                                                                                                                                                                                                                                                                                    |  | Alphonsine                                                                                                |  | VOIGHT                                                                                                                                                      |  |                                                                     |  | MAY 6, 1986                   |  |                    |  |                     |  |       |  | 7:55A M  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                   |  | 4. RACE                                                                                                   |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE                                                              |  | (IN YEARS LAST BIRTHDAY)      |  | 7. IF UNDER 1 YEAR |  | 8. IF UNDER 24 HRS. |  |       |  |          |  |
| Female                                                                                                                                                                                                                                                                                                                   |  | White                                                                                                     |  | Sept. 29 1906                                                                                                                                               |  | 79                                                                  |  |                               |  | MONTHS             |  | DAYS                |  | HOURS |  | MIN.     |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                               |  |                    |  |                     |  |       |  |          |  |
| Maryland                                                                                                                                                                                                                                                                                                                 |  | USA                                                                                                       |  |                                                                                                                                                             |  | BALTIMORE CITY                                                      |  |                               |  |                    |  |                     |  |       |  | MD.      |  |
| 7c. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                               |  |                    |  |                     |  |       |  |          |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                |  | JOHNS HOPKINS HOSPITAL                                                                                    |  | Housewife                                                                                                                                                   |  |                                                                     |  |                               |  |                    |  |                     |  |       |  |          |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                                               |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?                                            |  | 13. STREET ADDRESS            |  |                    |  |                     |  |       |  |          |  |
| Md.                                                                                                                                                                                                                                                                                                                      |  | Balto.                                                                                                    |  | Dundalk                                                                                                                                                     |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 101 Centre Pl. Apt. 617 21222 |  |                    |  |                     |  |       |  |          |  |
| FATHER'S NAME                                                                                                                                                                                                                                                                                                            |  | FIRST                                                                                                     |  | MIDDLE                                                                                                                                                      |  | LAST                                                                |  | 15. MOTHER'S MAIDEN NAME      |  | FIRST              |  | MIDDLE              |  | LAST  |  |          |  |
| Thomas                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  | Smart                                                                                                                                                       |  |                                                                     |  | Ellen                         |  |                    |  |                     |  | Quinn |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.                                                                                  |  | 17. INFORMATION                                                                                                                                             |  | ADDRESS                                                             |  |                               |  |                    |  |                     |  |       |  |          |  |
| no                                                                                                                                                                                                                                                                                                                       |  | 217-01-6348                                                                                               |  | Thomas Voight 6801 Harewood Park Dr. 21220                                                                                                                  |  |                                                                     |  |                               |  |                    |  |                     |  |       |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY:                                                                                                                                                                                                                 |  | IMMEDIATE CAUSE (a)                                                                                       |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                              |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |                               |  |                    |  |                     |  |       |  |          |  |
|                                                                                                                                                                                                                                                                                                                          |  | cardiac arrest                                                                                            |  |                                                                                                                                                             |  | 4d                                                                  |  |                               |  |                    |  |                     |  |       |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                           |  |                                                                                                           |  | (b) upper gastrointestinal bleed                                                                                                                            |  | 15 mo                                                               |  |                               |  |                    |  |                     |  |       |  |          |  |
|                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | (c) metastatic gallbladder cancer                                                                                                                           |  |                                                                     |  |                               |  |                    |  |                     |  |       |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                     |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                               |  |                    |  |                     |  |       |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20a. AUTOPSY?                                                                                                                                               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                               |  |                    |  |                     |  |       |  |          |  |
|                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                         |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                               |  |                    |  |                     |  |       |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                     |  |                               |  |                    |  |                     |  |       |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |  |                               |  |                    |  |                     |  |       |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 26, 19 86, to May 6, 19 86, that (I) (we) last saw the deceased alive on May 6, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>Daniel H Thomas MD                                                                      |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>5-6-86                                          |  |                               |  |                    |  |                     |  |       |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Daniel H Thomas MD                                                                                                                                                                                                                                                              |  | 22e. ADDRESS<br>Johns Hopkins Hosp, Baltimore                                                             |  |                                                                                                                                                             |  |                                                                     |  |                               |  |                    |  |                     |  |       |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                             |  | 23b. DATE                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                               |  |                    |  |                     |  |       |  |          |  |
| Burial                                                                                                                                                                                                                                                                                                                   |  | 5/9/86                                                                                                    |  | New Cathedral Cemetery                                                                                                                                      |  | Baltimore Maryland                                                  |  |                               |  |                    |  |                     |  |       |  |          |  |
| 24. FUNERAL DIRECTOR<br>Connelly Funeral Home 300 Mace Ave. 21221                                                                                                                                                                                                                                                        |  | 25a. DATE PROC. BY REGISTRAR 5-9-86                                                                       |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |  |                                                                     |  |                               |  |                    |  |                     |  |       |  |          |  |

174

00-00534

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14254

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                              |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|-----------------------------------|--|--------------------------------------|--|--------------------------|--|--------------|--|------|--|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                          |         | FIRST                                                        |  | MIDDLE                                                                        |  | LAST                              |  | 2a. DATE KNOWN OF DEATH              |  | MONTH                    |  | DAY          |  | YEAR |  | 2b. HOUR                                     |  |
| Michael                                                                                                                                                                                                      |         | R.                                                           |  | Voss                                                                          |  |                                   |  | X                                    |  | 5/                       |  | 31/          |  | 19   |  | 86                                           |  |
| 3. SEX                                                                                                                                                                                                       | 4. RACE | 5. DATE OF BIRTH                                             |  | 6. AGE (IN YEARS)                                                             |  | IF UNDER 1 YR.                    |  | IF UNDER 24 HRS.                     |  | 2c. DATE PRONOUNCED DEAD |  | MONTH        |  | DAY  |  | YEAR                                         |  |
| Male                                                                                                                                                                                                         | Black   | 7 18 54                                                      |  | 31 YRS.                                                                       |  |                                   |  |                                      |  | 5/                       |  | 31/          |  | 19   |  | 86                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                    |         | 7b. CITIZEN OF WHAT COUNTRY?                                 |  | 8. MARRIED                                                                    |  | NEVER MARRIED                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                          |  |              |  |      |  |                                              |  |
| Maryland                                                                                                                                                                                                     |         | U.S.A.                                                       |  | WIDOWED                                                                       |  | DIVORCED                          |  | Baltimore City                       |  |                          |  |              |  |      |  |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                    |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| Baltimore                                                                                                                                                                                                    |         | Maryland General Hospital                                    |  | Unemployed                                                                    |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                   |         | 13a. STATE                                                   |  | 13b. COUNTY                                                                   |  | 13c. CITY OR TOWN                 |  | 13d. INSIDE CITY LIMITS?             |  | 13e. STREET ADDRESS      |  |              |  |      |  |                                              |  |
| Maryland                                                                                                                                                                                                     |         |                                                              |  | Baltimore                                                                     |  | YES X NO                          |  | 2007 Etting St.                      |  | 21217                    |  |              |  |      |  |                                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                            |         | MIDDLE                                                       |  | LAST                                                                          |  | 15. MOTHER'S MAIDEN NAME          |  | MIDDLE                               |  | LAST                     |  |              |  |      |  |                                              |  |
| Cle                                                                                                                                                                                                          |         | A.                                                           |  | Boddie                                                                        |  | Annie                             |  |                                      |  | Voss                     |  |              |  |      |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                                 |         | (YES, NO, OR UNKNOWN)                                        |  | 16b. SOCIAL SECURITY NO.                                                      |  | 17. INFORMANT                     |  | ADDRESS                              |  |                          |  |              |  |      |  |                                              |  |
| No                                                                                                                                                                                                           |         |                                                              |  | 214-62-7091                                                                   |  | Annie Voss                        |  | 2007 Etting St.                      |  | 21217                    |  |              |  |      |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                    |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1 DEATH WAS CAUSED BY:                                                                                                                                                                                  |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| IMMEDIATE CAUSE (a) Stab Wound of Chest                                                                                                                                                                      |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                               |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:                                                                                                                |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                           |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| (c)                                                                                                                                                                                                          |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                           |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                       |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |  |                                                                               |  |                                   |  |                                      |  |                          |  | 20. AUTOPSY? |  |      |  |                                              |  |
|                                                                                                                                                                                                              |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  | YES X NO     |  |      |  |                                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH                                                                                                                                          |         | 21b. TIME OF INJURY                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK X NOT WHILE AT WORK                                                                                                                                                       |         | 21e. PLACE OF INJURY (SIT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION                                                                 |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
|                                                                                                                                                                                                              |         | street                                                       |  | 1920 1/2 Etting St., Balto. City, Md.                                         |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| 22a. I certify that I took charge of the remains described above. Held an Autopsy X Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide X Undetermined manner |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| TITLE (SPECIFY)                                                                                                                                                                                              |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| M.D. Assistant MEDICAL EXAMINER                                                                                                                                                                              |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| DATE SIGNED 5/31/86                                                                                                                                                                                          |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.                                                                                                                               |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                    |         | 23b. DATE                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY                                            |  | 23d. LOCATION                     |  | CITY OR TOWN                         |  | COUNTY                   |  | STATE        |  |      |  |                                              |  |
| Burial                                                                                                                                                                                                       |         | 6-4-86                                                       |  | Mount Zion Cemetery                                                           |  | Baltimore                         |  |                                      |  |                          |  | Maryland     |  |      |  |                                              |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS Bailey Funeral Home 1348 N. Calhoun St. 21217                                                                                                                              |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| 25a. DATE REC'D BY REGISTRAR JUN 5 1986                                                                                                                                                                      |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |
| 25b. REGISTRAR'S SIGNATURE [Signature]                                                                                                                                                                       |         |                                                              |  |                                                                               |  |                                   |  |                                      |  |                          |  |              |  |      |  |                                              |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

NO-00334

998110700 6008

CHIT + WAT + 1100





00-06250

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

1 4 2 5 5

|                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |                                                                          |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANNA NMI WADDELL</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 9 1986</b>                 |                                                                                                                                                             | 2b. HOUR<br><b>5<sup>40</sup> PM</b>                                                 |                                                                                                                                            |                                                                                                                            |                                                                                |  |
| 3. SEX<br><b>female</b>                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>white</b>                                                                                                              |                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 7 41</b>                                                                                                         |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>44 45</b> YRS                                                                                        |                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SCOTLAND</b>                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>GREAT BRITAIN</b>                                                                                 |                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                          |                                                                                                                            |                                                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY of MD</b> |                                                                          |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ASSISTANT</b>                                                       |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Microbiology LAB</b>                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                   |  |                                                                                                                                      |                                                                          |                                                                                                                                                             |                                                                                      | 13b. COUNTY<br><b>Baltimore</b>                                                                                                            |                                                                                                                            | 13c. STREET ADDRESS & ZIP CODE<br><b>214 Murgate Road 21107</b>                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES NMI WADDELL</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FLORA NMI DOWNIE</b> |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br><b>025-40-7687</b>                                                                                       |                                                                          | 17. INFORMANT<br>ADDRESS<br><b>Elizabeth Kolankowski</b>                                                                                                    |                                                                                      |                                                                                                                                            |                                                                                                                            | Same as # 13                                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>LIVER FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHRONIC RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                      |                                                                          |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>8 yrs</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                        |  |                                                                                                                                      |                                                                          |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                |  |
| 19a. DATE OF OPERATION<br><b>4-13-86</b>                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Rejected cadaveric transplant</b>                                             |                                                                          |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                         |                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |                                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                |  |
| 22a. I certify that (I, this hospital) attended the deceased from <b>4/1/86</b> , 19____, to <b>5/9/86</b> , 19____, that (I/we) lost<br>saw the deceased <b>5/9/86</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I/we) did (did not) view the body after death.                                              |  |                                                                                                                                      |                                                                          |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                |  |
| 22b. SIGNATURE<br><b>R. P. Zickler</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                      |                                                                          | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                      | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                                            | 22c. DATE SIGNED<br><b>5/9/86</b>                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Roderick P. Zickler MD</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                      |                                                                          | 22e. ADDRESS<br><b>22 S. Greene St. BALD MD 21201</b>                                                                                                       |                                                                                      |                                                                                                                                            |                                                                                                                            |                                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>05/10/86</b>                                                                                                         |                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process</b>                                                                                               |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Balto., MD</b>                                                                |                                                                                                                            |                                                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Cremation Society of MD</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |                                                                          | 24a. ADDRESS<br><b>299 Frederick Rd. Balto., MD 21228</b>                                                                                                   |                                                                                      | DATE REC'D. BY REGISTRAR<br><b>MAY 12 1986</b>                                                                                             |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                               |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2006-01-01

2006-01-01



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 5 6

REG. NO.

|                                                                                                                                                                                              |  |                                                                                             |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|---------------------|--|------|--|----------------------------------------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                          |  | FIRST                                                                                       |  | MIDDLE                                                                                                                                                   |  | LAST                                                                                                                                       |  | 6a. DATE OF DEATH                         |  | MONTH                                                                                                                   |  | DAY                 |  | YEAR |  | 7b. HOUR                                     |  | P |  |  |  |
| Alice A. Wajbel                                                                                                                                                                              |  |                                                                                             |  |                                                                                                                                                          |  |                                                                                                                                            |  | 5-5-86                                    |  |                                                                                                                         |  |                     |  |      |  | 8:51                                         |  | P |  |  |  |
| 3. SEX                                                                                                                                                                                       |  | 4. RACE                                                                                     |  | 5. DATE OF BIRTH                                                                                                                                         |  |                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)           |  |                                                                                                                         |  | 7a. IF UNDER 1 YEAR |  |      |  | 7b. IF UNDER 24 HRS                          |  |   |  |  |  |
| Female                                                                                                                                                                                       |  | white                                                                                       |  | 7 MONTH 20 DAY 21 YEAR                                                                                                                                   |  |                                                                                                                                            |  | 64 YRS.                                   |  |                                                                                                                         |  | MONTHS              |  |      |  | DAYS                                         |  |   |  |  |  |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                    |  | 8b. CITIZEN OF WHAT COUNTRY?                                                                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                     |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| Baltimore                                                                                                                                                                                    |  | —                                                                                           |  | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                                                                            |  | Baltimore City                            |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH CITY, COUNTY OR STATE) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  |                                                                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY         |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| Baltimore                                                                                                                                                                                    |  | Saint Johns Hospital                                                                        |  | Immediate                                                                                                                                                |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| 13a. RESIDENTIAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                           |  | 13b. COUNTY                                                                                 |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                               |  | 13e. STREET ADDRESS / ZIP CODE            |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| Md.                                                                                                                                                                                          |  | Baltimore                                                                                   |  | Baltimore                                                                                                                                                |  | YES                                                                                                                                        |  | 1463 Stensens, Lt                         |  |                                                                                                                         |  | 91230               |  |      |  |                                              |  |   |  |  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)                                                |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| William Perry                                                                                                                                                                                |  | Unknown                                                                                     |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)                                                                                                                          |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE)                                         |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                                                                                                    |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| No                                                                                                                                                                                           |  | 216-22-4152                                                                                 |  | Edmond J. Wajbel                                                                                                                                         |  | 1463 Stensens, Lt                                                                                                                          |  |                                           |  | 91230                                                                                                                   |  |                     |  |      |  |                                              |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY:                                                                                         |  | IMMEDIATE CAUSE (a)                                                                         |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                           |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |
| Cardiopulmonary arrest                                                                                                                                                                       |  |                                                                                             |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                |  |                                                                                             |  | (b)                                                                                                                                                      |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
|                                                                                                                                                                                              |  |                                                                                             |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                           |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
|                                                                                                                                                                                              |  |                                                                                             |  | (c)                                                                                                                                                      |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                          |  |                                                                                             |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                            |  |                                                                                                                                                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                     |  |                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                     |  |      |  |                                              |  |   |  |  |  |
|                                                                                                                                                                                              |  |                                                                                             |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
|                                                                                                                                                                                              |  |                                                                                             |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                       |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                          |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
|                                                                                                                                                                                              |  |                                                                                             |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-5 1986, to 5-5 1986, that (I) (we) lost                                                                                 |  |                                                                                             |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| saw the deceased alive on 5-5 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death, |  |                                                                                             |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| 22b. SIGNATURE                                                                                                                                                                               |  | DEGREE                                                                                      |  |                                                                                                                                                          |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                           |  | 22c. DATE SIGNED                                                                                                        |  |                     |  |      |  |                                              |  |   |  |  |  |
| Martin Guerrero MD                                                                                                                                                                           |  |                                                                                             |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                           |  | 5-5-86                                                                                                                  |  |                     |  |      |  |                                              |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                        |  | 22e. ADDRESS                                                                                |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| Martin Guerrero, MD                                                                                                                                                                          |  | 3001 So. Hanover, Balti., MD 2123                                                           |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL                                                                                                                                                              |  | 23b. DATE                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATOR                                                                                                                        |  |                                                                                                                                            |  | 23d. LOCATION (CITY OR TOWN) COUNTY STATE |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| Burial                                                                                                                                                                                       |  | 5/9/86                                                                                      |  | Holy Cross Cem.                                                                                                                                          |  |                                                                                                                                            |  | Baltimore                                 |  |                                                                                                                         |  | MD                  |  |      |  |                                              |  |   |  |  |  |
| 24. MEDICAL DIRECTOR                                                                                                                                                                         |  | 25a. DATE REC'D BY REGISTRAR                                                                |  |                                                                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                 |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |
| Charles J. Newhouse                                                                                                                                                                          |  | MAY 7 1986                                                                                  |  |                                                                                                                                                          |  | Julia Davidson-Randall                                                                                                                     |  |                                           |  |                                                                                                                         |  |                     |  |      |  |                                              |  |   |  |  |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

BP



00-09342

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 5 7

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                   |                                                                |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WALDRON, JOHN D                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 22 86                 |                                                                                                                                                             |  | 2b. HOUR<br>12:30 PM                                                                 |  |                                                                                                                               |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>Caucasian                                                                                              |                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 22 42                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>43 YRS.                                           |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>DISTRICT OF COLUMBIA                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                               |                                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE MD.                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UMMS |                                                                |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>PLUMBER                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>NONE.                                                                                    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME, GIVE STREET ADDRESS)<br>13b. STATE<br>MD                                                                                                                                                                                                                                                                                         |  | 13c. CITY OR TOWN<br>JUNK                                                                                         |                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS / ZIP CODE<br>JUNK 122 OAKWOOD RD.                               |  |                                                                                                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN WALDRON                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>IDA GIGLIOTTI |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>JUNK                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>215 403290                                                                            |                                                                | 17. INFORMANT<br>JOHN D. WALDRON                                                                                                                            |  | ADDRESS<br>SAME AS 13E<br>MEDICAL RECORD.                                            |  |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CAD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>HYPERTENSION</u>                                                                                        |  |                                                                                                                   |                                                                |                                                                                                                                                             |  |                                                                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>20 minutes                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>DIABETES MELLITUS</u>                                                                                                                                                                                                          |  |                                                                                                                   |                                                                |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                               |  |
| 19a. DATE OF OPERATION<br>18 MAY 86                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>INFECTED RIGHT STUMP                                          |                                                                |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                        |                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                      |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                            |                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                      |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4 MAY</u> 19 <u>86</u> , to <u>22 MAY</u> 19 <u>86</u> , that (I) (we) last<br>saw the deceased alive on <u>22 MAY</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                   |                                                                |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><u>PETER M. DARDI</u>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                   |                                                                | DEGREE<br>MD                                                                                                                                                |  |                                                                                      |  | 22c. DATE SIGNED<br>22 MAY 86                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PETER M. DARDI                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                   |                                                                | 22e. ADDRESS<br>UNIV. MD SYL. BALT MD 21201                                                                                                                 |  |                                                                                      |  |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>5-24-86                                                                                              |                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>LAKEMONT DAVIDSONVILLE                                                                                                |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br>A.A.CO. MARYLAND                     |  |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>ROBERT E. EVANS ANNAPOLIS                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                   |                                                                | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br>JULIA DAVIDSON-ROBERTS                                 |  |                                                                                                                               |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



00-07661

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14258

1. FOR  
STATE REGISTRAR  
Thomas Francis Ward

REG. NO.

|                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                |                                                                                       |                                                                                                                                                             |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 |                                                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Thomas Francis Ward</b>                                                                                                                                                                                                                                                  |  |                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>21</b> YEAR <b>86</b>                      |                                                                                                                                                             |                                       | 2b. HOUR<br><b>6:00</b> A.M.                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                 |                                                                      |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>Cauc</b>                                                                                                                         |                                                                                       | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>8</b> YEAR <b>09</b>                                                                                              |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Brooklyn ny</b>                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |                                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY, Baltimore</b> MD.                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 |                                                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JL Deaton Hosp. med Center</b> |                                                                                       |                                                                                                                                                             |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SEA CAPT</b>                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Merchant MARINE</b>          |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                | 13b. COUNTY<br><b>---</b>                                                             |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                      |  |
| 14. FATHER'S NAME<br>FIRST <b>James</b> MIDDLE <b>J</b> LAST <b>Ward</b>                                                                                                                                                                                                                                        |  |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Josephine</b> MIDDLE <b>V</b> LAST <b>Cooney</b> |                                                                                                                                                             |                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                                                                      |  |
| 16b. SOCIAL SECURITY NO.<br><b>133-01-0359</b>                                                                                                                                                                                                                                                                  |  |                                                                                                                                                | 17. INFORMANT<br><b>1011 Fidelity Building 21201</b><br><b>PATRICK A O'Boherty</b>    |                                                                                                                                                             |                                       | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myxofibrosis c myocardial metaplasia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Malnutrition</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Malnutrition</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Malnutrition</b> |                                                                                                 |                                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |                                                                                       | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19 86</b>                                                                           |                                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 |                                                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |                                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 |                                                                      |  |
| 22. I certify that (this hospital) attended the deceased from <b>5/21/86</b> to <b>5/21/86</b> , that (we) last saw the deceased alive on <b>5/21/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. |  |                                                                                                                                                |                                                                                       |                                                                                                                                                             |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 |                                                                      |  |
| 22a. SIGNATURE<br><b>J. Gladue, MD</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                |                                                                                       | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 | 22c. DATE SIGNED<br><b>5/21/86</b>                                   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gladue MD</b>                                                                                                                                                                                                                                                       |  |                                                                                                                                                |                                                                                       | 22e. ADDRESS<br><b>611 S. Charles Street Baltimore, MD 21230</b>                                                                                            |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 |                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>5/22/1986</b>                                                                                                                  |                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>                                                                                          |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, MD</b>                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 |                                                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Brooks Bradley, Inc. Balto., MD 21222</b>                                                                                                                                                                                                                             |  |                                                                                                                                                |                                                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 27 1986</b>                                                                                                         |                                       | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Anderson</b>                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                 |                                                                      |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete the necessary papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  | 86 14259<br>REG. NO.                                                                                                                                        |  |                                                                                                                            |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Flora E. Ware</u>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <u>May 24 1986</u>                                                                                                      |  |                                                                                                                            |                                              |
| 3. SEX <u>F</u>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             |  | 2b. HOUR <u>2:30</u> M                                                                                                                                      |  |                                                                                                                            |                                              |
| 4. RACE <u>B</u>                                                                                                                                                                                                                                                                                                                                                                                |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <u>05 20 05</u>                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>81</u> YRS.                                                                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>N.C.</u>                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                                                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                                                          |                                              |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>John Deaton MED. CENTER</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>retired</u>                                                                          |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             |  | 13a. STREET ADDRESS / ZIP CODE <u>3915 Calhoun Ave apt 209</u>                                                                                              |  |                                                                                                                            |                                              |
| 13a. STATE <u>MD</u>                                                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY <u>BALTO</u>                                                                                                                    |  | 13c. CITY OR TOWN <u>BALTO</u>                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <u>John Sawyer</u>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <u>Josephine Woodhouse</u>                                                                                    |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>No</u>                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br><u>212-30-9257</u>                                                                                              |  | 17. INFORMANT<br><u>Helen Mitchell</u>                                                                                                                      |  | ADDRESS<br><u>2537 Bearman Ave.</u>                                                                                        |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line; 19a, 19b, and 19c are optional.)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic edema</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Brain tumor</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Decubitus ulcers</u>                                                                                                                                                                                                                                 |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-30</u> , 19 <u>86</u> , to <u>5-21</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5-21</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><u>Marsha J. Brown</u> MD                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                             |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>5-21-86</u>                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Marsha J. Brown MD</u>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             |  | 22e. ADDRESS<br><u>844 N. Carey St. 21217</u>                                                                                                               |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><u>5/24/86</u>                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>King Memorial Park</u>                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Randallstown, Md.</u>                                                     |                                              |
| 24. FUNERAL DIRECTOR<br><u>Wm C March F.H West</u>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             |  | ADDRESS<br><u>4300 Wabash Ave.</u>                                                                                                                          |  | 25a. DATE REC'D BY REGISTRAR<br><u>MAY 23 1986</u>                                                                         |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Davidson-Randall</u>                                                                                                    |  |                                                                                                                            |                                              |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                         |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|-----------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                             |  | 6                                                                                                      |  | 1                                                                                                                                                        |  | 4                                                                   |  | 260                                     |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                   |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                   |  | LAST                                                                |  | 2a. DATE OF DEATH MONTH DAY YEAR        |                                              |
| George                                                                                                                                                                                                                                                                                                                                             |  | W.                                                                                                     |  | Warren                                                                                                                                                   |  | 05                                                                  |  | 31 86                                   |                                              |
| 3 SEX                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7b. HOUR                                |                                              |
| Male                                                                                                                                                                                                                                                                                                                                               |  | White                                                                                                  |  | 11 02 22                                                                                                                                                 |  | 63                                                                  |  | M                                       |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                         |                                              |
| Maryland                                                                                                                                                                                                                                                                                                                                           |  | USA                                                                                                    |  |                                                                                                                                                          |  | Baltimore City                                                      |  | MD.                                     |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                         |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                                                          |  | 3024 Remington Avenue 21211                                                                            |  | Retired                                                                                                                                                  |  |                                                                     |  |                                         |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS, / ZIP CODE         |                                              |
| Maryland                                                                                                                                                                                                                                                                                                                                           |  | --                                                                                                     |  | Baltimore                                                                                                                                                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3024 Remington Ave. 21211               |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                             |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                |  | 17. INFORMANT ADDRESS                   |                                              |
| Ward R. Warren                                                                                                                                                                                                                                                                                                                                     |  | Abbie Belle Foreman                                                                                    |  | Yes                                                                                                                                                      |  | WW II 219-12-1514                                                   |  | Vivian Warren 3024 Remington Ave. 21211 |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>pulmonary emphysema</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>gave rise to immediate cause (a), stating the underlying cause lost</u> |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                         |                                              |
|                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                         |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |                                                                     |  |                                         |                                              |
|                                                                                                                                                                                                                                                                                                                                                    |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                     |  |                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |  |                                         |                                              |
|                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                         |                                              |
| 22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                         |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                     |  | DEGREE                                                                                                 |  | 22c. DATE SIGNED                                                                                                                                         |  |                                                                     |  |                                         |                                              |
| <u>William M. Parham, III</u>                                                                                                                                                                                                                                                                                                                      |  | MD                                                                                                     |  | 6/21/86                                                                                                                                                  |  |                                                                     |  |                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                              |  | 22e. ADDRESS                                                                                           |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |                                                                     |  |                                         |                                              |
| William M. Parham, III                                                                                                                                                                                                                                                                                                                             |  | 3100 Wyman Park Drive Balto 21211                                                                      |  |                                                                                                                                                          |  |                                                                     |  |                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                          |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |                                         |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                             |  | 6/4/86                                                                                                 |  | Lake View Mem. Pk.                                                                                                                                       |  | Baltimore Maryland                                                  |  |                                         |                                              |
| 24. FUNERAL DIRECTOR NAME ADDRESS                                                                                                                                                                                                                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |  |                                                                     |  |                                         |                                              |
| A. Alan Seitz, Jr. 3615-19 Chestnut Ave. 21211                                                                                                                                                                                                                                                                                                     |  | JUN 2 1986                                                                                             |  | <u>James W. Gordon</u>                                                                                                                                   |  |                                                                     |  |                                         |                                              |

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0-08012Item, Part, II., G-620, 10/7/86  
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

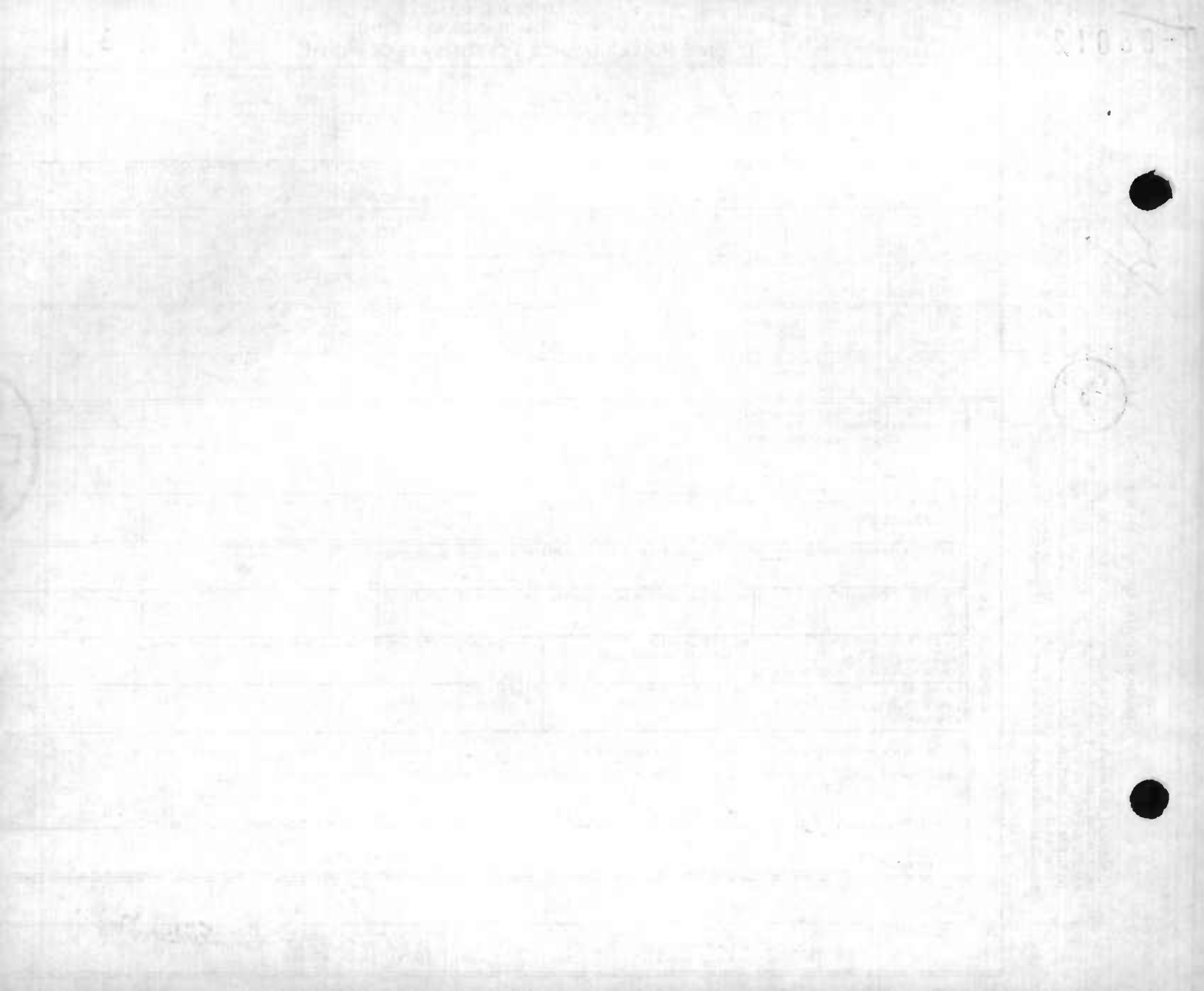
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|                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                               |  |                                                                 |  |                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------|--|-----------------------------------------------------------------|--|-------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                           |  | FIRST                                                                                                      |  | MIDDLE                                                                                                                                                      |  | LAST                                                                                            |  | 2a. DATE KNOWN<br>OF DEATH    |  | ESTIMATED<br><input checked="" type="checkbox"/> MONTH DAY YEAR |  | 2b. HOUR                                        |  |
| NARCISUS                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | WARREN                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  | 5-20-86                       |  | 9                                                               |  | am                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE                                                                                                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY                                                              |  | IF UNDER 1 YR.<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN                                   |  | 2c. DATE<br>PRONOUNCED<br>DEAD                  |  |
| FEmale                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | Black                                                                                                      |  | 9 30 26                                                                                                                                                     |  | 59                                                                                              |  | FRS.                          |  |                                                                 |  | 5-26-86                                         |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                            |  |                               |  |                                                                 |  |                                                 |  |
| North Carolina                                                                                                                                                                                                                                                                                                                                                                                                                                |  | U.S.A.                                                                                                     |  |                                                                                                                                                             |  | Baltimore City                                                                                  |  |                               |  |                                                                 |  |                                                 |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                                            |  |                               |  |                                                                 |  |                                                 |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 2000 Odell Avenue                                                                                          |  | N/A                                                                                                                                                         |  |                                                                                                 |  |                               |  |                                                                 |  |                                                 |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY                                                                                                |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS           |  |                                                                 |  |                                                 |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                            |  | Baltimore                                                                                                                                                   |  |                                                                                                 |  | 2000 Odell Avenue APT. 908    |  |                                                                 |  |                                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                              |  |                                                                                                                                                             |  |                                                                                                 |  |                               |  |                                                                 |  |                                                 |  |
| Andrew                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | Porter, Jr.                                                                                                |  | Narcissus                                                                                                                                                   |  | Smith                                                                                           |  |                               |  |                                                                 |  |                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.                                                                                   |  | 17. INFORMANT                                                                                                                                               |  | ADDRESS                                                                                         |  |                               |  |                                                                 |  |                                                 |  |
| NO                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 215-28-2685                                                                                                |  | Pearl Ewing                                                                                                                                                 |  | 3811 Ferndale Avenue                                                                            |  |                               |  |                                                                 |  |                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                 |  |                                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                               |  |                                                                 |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a)<br><u>Alcoholism</u>                                                                                                                                                                                                                                                                                        |  |                                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                               |  |                                                                 |  |                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                          |  | 20. AUTOPSY?<br>(HEAD ONLY)<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                          |  |                                                                                                 |  |                               |  |                                                                 |  |                                                 |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                 |  |                               |  |                                                                 |  |                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                               |  |                                                                 |  |                                                 |  |
| 22a. I certify that I took charge of the remains described above and (HEAD ONLY) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                               |  |                                                                 |  |                                                 |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                              |  | TITLE (SPECIFY)                                                                                            |  | M.D. Assistant MEDICAL EXAMINER                                                                                                                             |  | DATE SIGNED                                                                                     |  | 5-26-86                       |  |                                                                 |  |                                                 |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                            |  | ADDRESS                                                                                                    |  |                                                                                                                                                             |  |                                                                                                 |  |                               |  |                                                                 |  |                                                 |  |
| Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 111 Penn Street                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                               |  |                                                                 |  |                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(S) BURIAL                                                                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE<br>5/29/86                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus MEmorial Park                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |  | Arbutus, Md                   |  |                                                                 |  |                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                                  |  | ADDRESS                                                                                                    |  | 25a. DATE REC'D BY REGISTRAR                                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE                                                                      |  |                               |  |                                                                 |  |                                                 |  |
| March Funeral Homes                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 1101 East North avenue                                                                                     |  | MAY 29 1986                                                                                                                                                 |  | John A. ...                                                                                     |  |                               |  |                                                                 |  |                                                 |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONE. WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))





00-07193

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 2 6 2  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                |                                                                   |                                                                                                                                                             |                     |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SARAH WASHINGTON                                                                                                                                                                                                                                                                         |  |                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5-16-86                    |                                                                                                                                                             | 2b. HOUR<br>1145 AM |                                                                                                                            |  |
| 3. SEX<br>F                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>B                                                                                                                   |                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8-18-16                                                                                                               |                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NC                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                            |                                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3018 FREESTMAN ST |                                                                   | 12a. USUAL OCCUPATION<br>(IF FIELD OF WORK FOR MOST OF WORKING LIFE)<br>Domestic Wk Family                                                                  |                     | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br>BALTIMORE                                                                                                       |                                                                   | 13c. STREET ADDRESS / ZIP CODE<br>3018 FREESTMAN ST                                                                                                         |                     |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN SQUINE                                                                                                                                                                                                                                                                           |  |                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>IDA SQUINE 21216 |                                                                                                                                                             |                     |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, FOLD OVER NOW)                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>215-09-4421                                                                                        |                                                                   | 17. INFORMANT<br>ADDRESS<br>Marie Donovan 3018 Freestman St                                                                                                 |                     |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cancer of lung<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                |                                                                   |                                                                                                                                                             |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 months                                                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.                                                                                                                                                                                                |  |                                                                                                                                |                                                                   |                                                                                                                                                             |                     |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |                                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                     |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>Hospice                                              |                                                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                     |                                                                                                                            |  |
| 22a. I certify that (this physician attended the deceased from April 18, 1986, to May 16, 1986, that (1) (we) last saw the deceased alive on May 12, 1986, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.                      |  |                                                                                                                                |                                                                   |                                                                                                                                                             |                     |                                                                                                                            |  |
| 22b. SIGNATURE<br>W.B. Daniels, Jr.                                                                                                                                                                                                                                                                                             |  | DEGREE<br>MD                                                                                                                   |                                                                   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                     | 22c. DATE SIGNED<br>5/19/86                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>W.B. Daniels, Jr.                                                                                                                                                                                                                                                                      |  | 22e. ADDRESS<br>Union Memorial Hospice, Baltimore 21218                                                                        |                                                                   |                                                                                                                                                             |                     |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK IF)<br>REMOVE                                                                                                                                                                                                                                                                         |  | 23b. DATE<br>5/22/86                                                                                                           |                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br>Family Plot Spaworth Burial N.C.                                                                                      |                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Maurice A. Hays                                                                                                                                                                                                                                                                                 |  | ADDRESS<br>108 N. Gilman St                                                                                                    |                                                                   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 21 1986                                                                                                                |                     | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson                                                                               |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial permit. They please remove prior to page 1, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, or other findings, the physician must be notified immediately.

BP



00-07435

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 6 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                              |                                                                                          |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                |                                                                                                                            |                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Queen E. Waters                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 15, 1986                                      |                                                                                                                                                             |                                                                                                                                                      | 2b. HOUR<br>5 P.M.                                                                              |                                                                |                                                                                                                            |                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>Black                                                                                                             |                                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-18-1914                                                                                                            |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71<br>YRS                                                    |                                                                | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                          |                                                                                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, Maryland MD.                                 |                                                                |                                                                                                                            |                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2836 Riggs Ave. |                                                                                          |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                                                | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                            |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                              |                                                                                          |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                |                                                                                                                            |                                                            |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY                                                                                                                  |                                                                                          | 13c. CITY OR TOWN<br>Balto.                                                                                                                                 |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                | 13e. STREET ADDRESS / ZIP CODE<br>2836 Riggs Ave. 21216                                                                    |                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Stokes                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                              |                                                                                          |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Hattie Stokes                                                                                       |                                                                                                 |                                                                |                                                                                                                            |                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                              | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>215-12-5144                    |                                                                                                                                                             |                                                                                                                                                      | 17. INFORMANT<br>ADDRESS<br>McCoy Waters 2836 Riggs Ave.                                        |                                                                |                                                                                                                            |                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), or (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>ASHD Congestive Heart Failure</u><br>(c) <u>Diabetes, Chronic Renal Failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |                                                                                                                              |                                                                                          |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u><br><u>years</u>                                             |                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                                                                                                                                                             |                                                                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                               |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                                                 |                                                                |                                                                                                                            |                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                              | 21e. PLACE OF INJURY<br>(IF HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>at home</u> |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>2836 Riggs Ave. Balto. Md.</u>                                                               |                                                                                                 |                                                                |                                                                                                                            |                                                            |  |
| 22. I certify that (a) (this hospital) attended the deceased from <u>12/84</u> 19 <u>84</u> to <u>5/15</u> 19 <u>86</u> , that (b) (we) lost the deceased on <u>5/16</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (and) (the) (not) saw the body after death.                                                                                                                                                                                    |  |                                                                                                                              |                                                                                          |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                |                                                                                                                            |                                                            |  |
| 22a. SIGNATURE<br><u>Donald M. Pachuta</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                              |                                                                                          |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22b. DATE SIGNED<br><u>5/16/86</u>                             |                                                                                                                            |                                                            |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Donald M. Pachuta</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                              |                                                                                          |                                                                                                                                                             | 22e. ADDRESS<br><u>2903 N. Charles Balto 21218</u>                                                                                                   |                                                                                                 |                                                                |                                                                                                                            |                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                              | 23b. DATE<br>5/20/86                                                                     |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Park                                                                                              |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus B.C. Md. |                                                                                                                            |                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles A. Rice FSPA 1300 Eutaw Pl,                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                              |                                                                                          |                                                                                                                                                             | ADDRESS                                                                                                                                              |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>MAY 23 1986                   |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson Spadell</u> |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-06685

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 1 4 2 6 4

|                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                 |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Drena J. Watkins                                                                                                                                                                                                                                                                                                         |                                                                                                                                 |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>May 11, 1986                               |                                                                                      | 2b. HOUR<br>M                                                                                                              |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                     | 4. RACE<br>Black                                                                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 23 70                                                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>15<br>YRS                                   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS                      |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                    |                                                                                      |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1927 Maulsby Court |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Unemployed | 12b. KIND OF BUSINESS OR INDUSTRY                                                    |                                                                                                                            |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                 |                                                                                                                                                             | 13b. COUNTY                                                                    | 13c. CITY OR TOWN<br>Baltimore                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Steven Watkins                                                                                                                                                                                                                                                                                                                             |                                                                                                                                 |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Dorothy M. Walker             |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                           |                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br>N/A                                                                                                                             | 17. INFORMANT ADDRESS<br>STEVEN WATKINS 1927 MAULSBY COURT 21237               |                                                                                      |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>severe brain damage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>birth</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |                                                                                                                                 |                                                                                                                                                             |                                                                                |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>immediate                                                                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u>                                                                                                                                                                                                                                         |                                                                                                                                 |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                             |                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                      |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                         |                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                      |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/12</u> , 19 <u>82</u> , to <u>5/11</u> , 19 <u>86</u> , that (I/we) last saw the deceased alive on <u>4/2</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.                           |                                                                                                                                 |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br><u>Thomas M. Lock, M.D.</u>                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                 | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                | 22c. DATE SIGNED<br>5/12/86                                                          |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>THOMAS M. LOCK, M.D.                                                                                                                                                                                                                                                                                                                        |                                                                                                                                 | 22e. ADDRESS<br>707 N. BROADWAY, BALTIMORE, MD 21205                                                                                                        |                                                                                |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                               | 23b. DATE<br>5/16/86                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.                                                                                                       | 23d. LOCATION<br>Anne Arundel Co., Md.                                         |                                                                                      |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>March Funeral Homes                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                 | 1101 East North Ave.                                                                                                                                        |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br>MAY 15 1986                                         | 25b. REGISTRAR'S SIGNATURE<br><u>John Anderson</u>                                                                         |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column 4, page 1 and 2, which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

LIBRARY

LIBRARY



00-08668

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

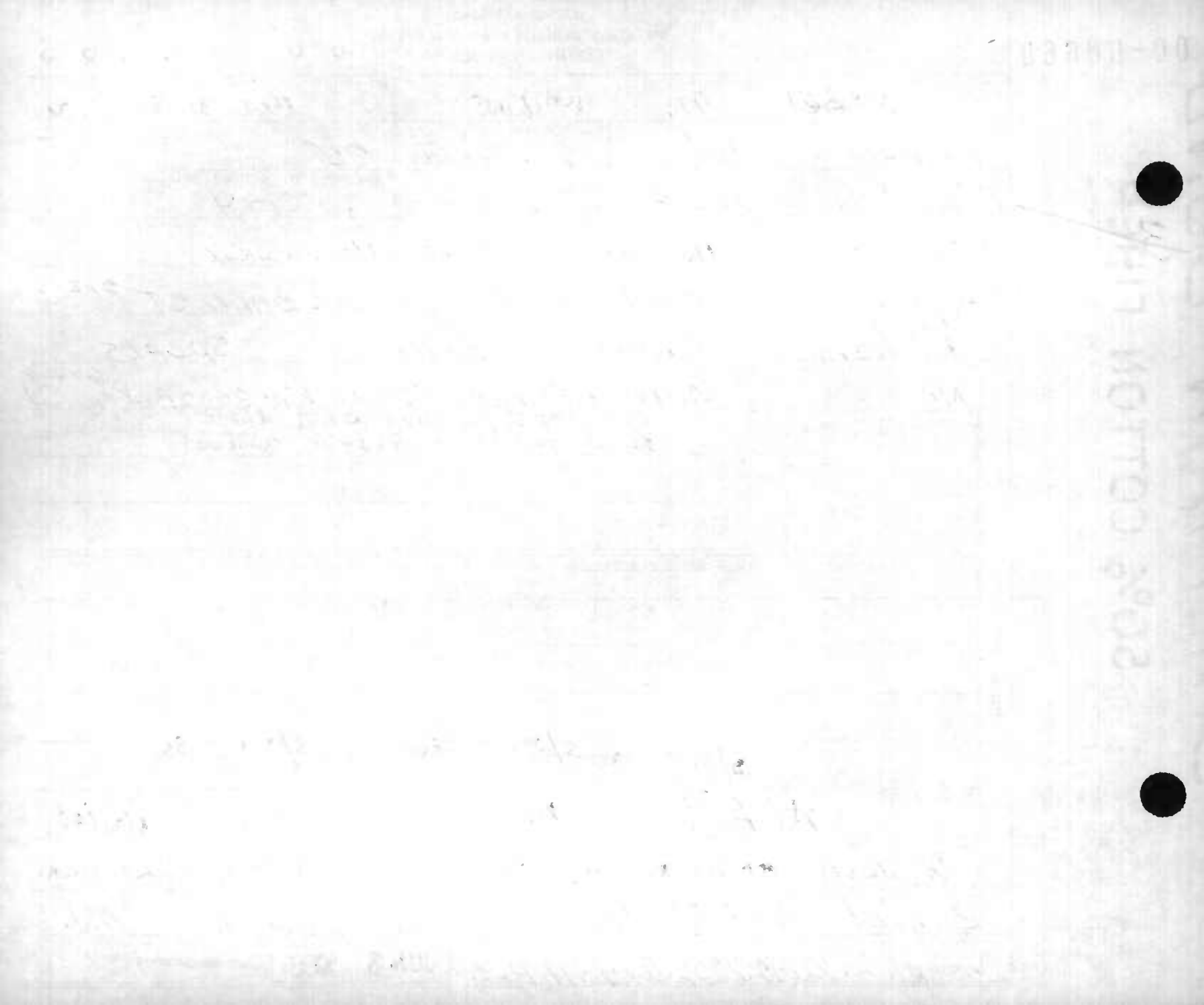
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                        |  |                                                                                                                           |  | 8 6 1 4 2 6 5<br>REG. NO.                                                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                      |  |                                                                                                                           |  |                                                                               |  |
| 1 DECEASED NAME (TYPE OR PRINT) MABLE M. WATKINS                                                                                                                                                                                                                                                            |  |                                                                                                                           |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR MAY 31 86 7:10 AM                   |  |
| 3 SEX Female                                                                                                                                                                                                                                                                                                |  | 4 RACE Col                                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR 6-15-1910                                     |  |
| 6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS                                                                                                                                                                                                                                                                       |  | 7. UNDER 1 YEAR MONTHS DAYS                                                                                               |  | 8. UNDER 24 HRS HOURS MIN                                                     |  |
| 7a BIRTHPLACE (STATE OR FOREIGN) Richmond Va.                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY? U. S. A                                                                                      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY. MD.                                |  |
| 10 CITY OR TOWN OF DEATH BALTIMORE                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker       |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                           |  | 13a. STREET ADDRESS / ZIP CODE 3002 BAKER ST 21216                                                                        |  |                                                                               |  |
| 13a STATE Maryland                                                                                                                                                                                                                                                                                          |  | 13b COUNTY Baltimore                                                                                                      |  | 13c CITY OR TOWN Baltimore                                                    |  |
| 14 FATHER'S NAME Richard BROWN                                                                                                                                                                                                                                                                              |  | 15 MOTHER'S MAIDEN NAME Belle SPEARS                                                                                      |  |                                                                               |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO                                                                                                                                                                                                                                         |  | 16b SOCIAL SECURITY NO. 220-18-7477                                                                                       |  | 17. INFORMANT ADDRESS Miss Carolyn WATKINS 3002 BAKER ST 21216                |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Renal failure & metabolic acidosis                                                                                                                                                 |  |                                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                                                                                                                                                                                          |  |                                                                                                                           |  |                                                                               |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                          |  |                                                                                                                           |  |                                                                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                              |  |                                                                                                                           |  |                                                                               |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                       |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |  | 20a AUTOPSY? YES NO                                                           |  |
| 21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                       |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK                                                                                                                                                                                                                                                         |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                        |  | 21f LOCATION CITY OR TOWN COUNTY STATE                                        |  |
| 22a I certify that (I) (this hospital) attended the deceased from 5/27 1986, to 5/31 1986, that (I) (we) lost saw the deceased alive on 5/31 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                           |  |                                                                               |  |
| 22b SIGNATURE ADAS. wa                                                                                                                                                                                                                                                                                      |  |                                                                                                                           |  | 22c DATE SIGNED 5/31/86                                                       |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) DASILVA ANTHONY A.                                                                                                                                                                                                                                                     |  |                                                                                                                           |  | 22e ADDRESS PROVIDENT HOSPITAL, BALTIMORE.                                    |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                             |  | 23b DATE 6-4-86                                                                                                           |  | 23c NAME OF CEMETERY OR CREMATORY Crownsville Mt. Cem.                        |  |
| 23d LOCATION (CITY OR TOWN) Crownsville                                                                                                                                                                                                                                                                     |  | 23e COUNTY Md.                                                                                                            |  | 23f STATE                                                                     |  |
| 24 FUNERAL DIRECTOR NAME Joseph L. Russ 2322 W. North Ave.                                                                                                                                                                                                                                                  |  |                                                                                                                           |  | 25a DATE REC'D. BY REGISTRAR JUN 3 1986                                       |  |
| 25b REGISTRAR'S SIGNATURE John Davidson                                                                                                                                                                                                                                                                     |  |                                                                                                                           |  |                                                                               |  |



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                        |  |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                       |  | 6                                                                                                      |  | 1                                                                                                                                                       |  | 4                                                                                                                      |  | 266                                          |  |
| 1a DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                             |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                  |  | LAST                                                                                                                   |  | 2a DATE OF DEATH MONTH DAY YEAR              |  |
| REBECCA                                                                                                                                                                                                                                                                                                      |  | WATKINS                                                                                                |  |                                                                                                                                                         |  |                                                                                                                        |  | 5 1 86                                       |  |
| 3. SEX                                                                                                                                                                                                                                                                                                       |  | 4 RACE                                                                                                 |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                         |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                                                                         |  | 7b HOUR                                      |  |
| F                                                                                                                                                                                                                                                                                                            |  | B                                                                                                      |  | 1 25 58                                                                                                                                                 |  | 88                                                                                                                     |  | 11 15 AM                                     |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                     |  | 7b CITIZEN OF WHAT COUNTRY?                                                                            |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                                                    |  |                                              |  |
| VA.                                                                                                                                                                                                                                                                                                          |  | U. S. A.                                                                                               |  |                                                                                                                                                         |  | Baltimore City                                                                                                         |  | MD.                                          |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b KIND OF BUSINESS OR INDUSTRY                                                                                       |  |                                              |  |
| Baltimore                                                                                                                                                                                                                                                                                                    |  | SINAI HOSPITAL                                                                                         |  | DOMESTIC                                                                                                                                                |  |                                                                                                                        |  |                                              |  |
| 13a STATE                                                                                                                                                                                                                                                                                                    |  | 13b COUNTY                                                                                             |  | 13c CITY OR TOWN                                                                                                                                        |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e STREET ADDRESS / ZIP CODE                |  |
| MD                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | Baltimore                                                                                                                                               |  |                                                                                                                        |  | 21217                                        |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                           |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                              |  |                                                                                                                                                         |  |                                                                                                                        |  |                                              |  |
| HENRY                                                                                                                                                                                                                                                                                                        |  | HARRIS                                                                                                 |  | SALLY                                                                                                                                                   |  |                                                                                                                        |  |                                              |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                             |  | 16b SOCIAL SECURITY NO.                                                                                |  | 17 INFORMANT ADDRESS                                                                                                                                    |  |                                                                                                                        |  |                                              |  |
| NO                                                                                                                                                                                                                                                                                                           |  | 220-34-6254                                                                                            |  | REBECCA GALE                                                                                                                                            |  | 1683 Freedom Way North                                                                                                 |  |                                              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                         |  | IMMEDIATE CAUSE (a)                                                                                    |  | DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                                      |  | DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|                                                                                                                                                                                                                                                                                                              |  | Cardio Vascular collapse.                                                                              |  | CHF, ASCVD                                                                                                                                              |  | + PLE                                                                                                                  |  |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                          |  | PVD, cerebral vascular disease, Dementia.                                                              |  |                                                                                                                                                         |  |                                                                                                                        |  |                                              |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                        |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                        |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                             |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                            |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                            |  |                                                                                                                        |  |                                              |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                               |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                        |  |                                              |  |
| 22a I certify that (I) (this hospital) attended the deceased from 4/25 19 86, to 5/1 19 86, that (I) (we) last saw the deceased alive on 5/1 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                         |  |                                                                                                                        |  |                                              |  |
| 22b SIGNATURE                                                                                                                                                                                                                                                                                                |  | DEGREE                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>              |  | 22c DATE SIGNED                                                                                                        |  |                                              |  |
| Eishele ZEV Liberman                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                         |  | 5/1/86.                                                                                                                |  |                                              |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                         |  | 22e ADDRESS                                                                                            |  |                                                                                                                                                         |  |                                                                                                                        |  |                                              |  |
| Eishele ZEV Liberman                                                                                                                                                                                                                                                                                         |  | Sinai Hospital Baltimore MD                                                                            |  |                                                                                                                                                         |  |                                                                                                                        |  |                                              |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                     |  | 23b DATE                                                                                               |  | 23c NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d LOCATION CITY OR TOWN COUNTY STATE                                                                                 |  |                                              |  |
| BURIAL                                                                                                                                                                                                                                                                                                       |  | 5-7-86                                                                                                 |  | ARBUTUS Mem. PK.                                                                                                                                        |  | ARBUTUS MD.                                                                                                            |  |                                              |  |
| 24 FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                          |  | 24a ADDRESS                                                                                            |  | 25a DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b REGISTRAR'S SIGNATURE                                                                                              |  |                                              |  |
| REDD FUNERAL HOME - 5204 YORK RD.                                                                                                                                                                                                                                                                            |  | BALTO. MD. 21212                                                                                       |  | MAY 7 1986                                                                                                                                              |  |                                                                                                                        |  |                                              |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMH - 16 60M 7/B4  
(VRA 15, 4)FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 6 7

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                     |                                                                       |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BOOKER T. WATSON                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 12 86                        |                                                                                                                                                             |                                                                                | 2b. HOUR<br>350 M                                                                    |                                                                                                 |                                                                                                                            |  |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>B                                                                                                                        |                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 20 16                                                                                                               |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69                                                |                                                                                                 |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                              |                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, CITY MD.                          |                                                                                                 |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1013 W. LANVALE STREET |                                                                       |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BEH-STEEL        |                                                                                                 |                                                                                                                            |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>COOK                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |                                                                       |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                        |  |                                                                                                                                     | 13b. COUNTY                                                           |                                                                                                                                                             | 13c. CITY OR TOWN<br>BALTIMORE                                                 |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BOTT WATSON                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>AMANDA WILLIAMS      |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br>215096453                                 |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>LAURA COTTON 2440 GUILFORD AVE.                    |                                                                                      |                                                                                                 |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hepatotoxicity 2° metastases</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Small cell lung cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                     |                                                                       |                                                                                                                                                             |                                                                                |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 mos.                                          |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>                                                                                                                                                                                                                                                      |  |                                                                                                                                     |                                                                       |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                      |  |                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                      |                                                                                                 |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                  |  |                                                                                                                                     | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                      |                                                                                                 |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>86</u> , to <u>13 May</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                            |  |                                                                                                                                     |                                                                       |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Carla A. Alexander, MD</u><br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                                       |  |                                                                                                                                     |                                                                       |                                                                                                                                                             |                                                                                | 22c. DATE SIGNED<br><u>5/13/86</u>                                                   |                                                                                                 |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>CARLA S. ALEXANDER</u>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                     |                                                                       |                                                                                                                                                             |                                                                                | 22e. ADDRESS<br><u>UNIV OF MD CANCER CTR</u>                                         |                                                                                                 |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                     | 23b. DATE<br>5-17-86                                                  |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>MARYLAND NATIONAL                        |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>LAUREL</u> MARYLAND                            |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>WM.C. MARCH F/H INC. 1101 E. NORTH AVE.                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                     |                                                                       |                                                                                                                                                             |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br>MAY 16 1986                                         |                                                                                                 |                                                                                                                            |  |
| 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |                                                                       |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must sign at the bottom of page 3.

00000000



MAY 16 1966

0-07811

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 6 8

REG. NO.

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  |                                                                        |                                                                                                                                                            |                                                       |                                                                                          |                                                                                                 |                                                                                                                               |                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>JESSIE NM1 WATSON                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 24 86                         |                                                                                                                                                            |                                                       | 2b. HOUR<br>5 30 PM                                                                      |                                                                                                 |                                                                                                                               |                                                          |  |
| 3 SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4 RACE<br>B                                                                                                                      |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 25 20                                                                                                             |                                                       | 6 AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS                                                 |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |                                                          |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>N.C.                                                                                                                                                                                                                                                                                                                                                                  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                            |                                                                        | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.                                         |                                                                                                 |                                                                                                                               |                                                          |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |                                                                        |                                                                                                                                                            |                                                       | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired taxicab owner |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |                                                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                  | 13b. COUNTY<br>Baltimore                                               |                                                                                                                                                            | 13c. CITY OR TOWN<br>Baltimore                        |                                                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                               | 13e. STREET ADDRESS / ZIP CODE<br>126 N. Mount St. 21223 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Bruce NM1 Watson                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Courtney NM1 Barnes   |                                                                                                                                                            |                                                       |                                                                                          |                                                                                                 |                                                                                                                               |                                                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>242-147252                                                            |                                                                        | 17. INFORMANT<br>ADDRESS<br>Ella. Watson 2000 Odell Ave.                                                                                                   |                                                       |                                                                                          |                                                                                                 |                                                                                                                               |                                                          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic lung cancer<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br>End Stage Renal Disease |  |                                                                                                                                  |                                                                        |                                                                                                                                                            |                                                       |                                                                                          |                                                                                                 |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                            |                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |                                                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                             |  |                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                            |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)            |                                                                                                 |                                                                                                                               |                                                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                        |                                                                                                 |                                                                                                                               |                                                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/16, 19 86, to 5/24, 19 86, that (I) (we) last saw the deceased alive on 5/24, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                   |  |                                                                                                                                  |                                                                        |                                                                                                                                                            |                                                       |                                                                                          |                                                                                                 |                                                                                                                               |                                                          |  |
| 22b. SIGNATURE<br>Scott A. Bergum                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  | DEGREE                                                                 |                                                                                                                                                            |                                                       | 22c. DATE SIGNED<br>5/24/86                                                              |                                                                                                 |                                                                                                                               |                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Scott A. Bergum                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  | 22e. ADDRESS<br>22 S. Greene St. University Hospital Bldg. MD 21201    |                                                                                                                                                            |                                                       |                                                                                          |                                                                                                 |                                                                                                                               |                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  | 23b. DATE<br>5/29/86                                                   |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem. |                                                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. MD                                         |                                                                                                                               |                                                          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March E/H 1101 E. North Ave                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  |                                                                        |                                                                                                                                                            |                                                       | 25a. DATE REC'D. BY REGISTRAR<br>MAY 28 1986                                             |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>Davidson-Randall                                                                                |                                                          |  |

MEDICAL CERTIFICATION

170

18

35

200

1

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2

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BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEMO

93617

100-808

WINTER





00-06426

Film GUS item 1

FOR 5/19/86 rja  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14269

REG. NO.

|                                                                                                                         |  |                                                                                                                                                  |                                                       |                                                                                                                                                             |                                       |                                                                                               |                                                                                                 |                                                  |                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joseph Marcellus Weatherly</b>                                                   |  |                                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 12 86</b> |                                                                                                                                                             |                                       | 2b. HOUR<br><b>3:40 AM</b>                                                                    |                                                                                                 |                                                  |                                                                        |  |
| 3. SEX<br><b>Male</b>                                                                                                   |  | 4. RACE<br><b>Caucasian</b>                                                                                                                      |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 16 06</b>                                                                                                       |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>                                                  |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b> |                                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Delaware</b>                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                       |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                             |                                                                                                 |                                                  |                                                                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hosp</b> |                                                       |                                                                                                                                                             |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Post Office Worker</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mail</b> |                                                                        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b> |  |                                                                                                                                                  | 13b. COUNTY<br><b>---</b>                             |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b> |                                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                  | 13e. STREET ADDRESS / ZIP CODE<br><b>415 Maude Ave Delivery 2 1225</b> |  |

|                                                                                   |  |                                                                              |                                                                             |                                                                                                     |  |
|-----------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--|
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Wilson Weatherly</b>          |  |                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillie Cannon Ellis</b> |                                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>21501 0783</b> |                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Joseph M. Weatherly Towson, Md. 21204 Terrace 7716-36 Greenville</b> |  |

|                                                                                                                                                              |  |                                                                   |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>minutes</b> |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis</b>                                                                                                          |  | <b>days</b>                                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                        |  |                                                                   |  |

|                                                                                                                                                                                                                                                                              |  |                                                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:1a<br><b>Ruptured Esophagus</b>                                                                                                              |  |                                                                                                                               |  |
| 19a. DATE OF OPERATION<br><b>4-18-86</b>                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ruptured Esophagus</b>                                                 |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                         |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                             |  |
| 21c. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                               |  | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                        |  |
| 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                            |  |                                                                                                                               |  |
| 22a. I certify that (i) this hospital attended the deceased from <b>4/4 19 86</b> to <b>5/12 19 86</b> that (i) (we) last saw the deceased alive on <b>5/12 19 86</b> and that (ii) (my) (our) opinion death occurred on the date and hour and from the causes stated above. |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Leonard Lamont MD</b>                                                                                                                                                                                                                                   |  | 22c. DATE SIGNED<br><b>5/12/86</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Leonard Lamont MD</b>                                                                                                                                                                                                            |  | 22e. ADDRESS<br><b>3001 S. Hanover St Balt. MD 21230</b>                                                                      |  |

|                                                                                          |  |                             |  |                                                                |  |                                                                               |  |
|------------------------------------------------------------------------------------------|--|-----------------------------|--|----------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                               |  | 23b. DATE<br><b>5/15/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Pk</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, AA Co., Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>McCully Funeral Homes 237 E. Patapsco Ave</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>5/13/86</b>                |  |                                                                               |  |
|                                                                                          |  |                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>             |  |                                                                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified at once.



7

2025 COLTON RIDGE  
APRIL 10TH 1902

0-05955

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8-6

1 4 2 7 0

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                          |                                                           |                                                                                                                                                             |                                                                                           |                                                                                                                            |                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>VIRGINIA WEAVER</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 7, 1986</b> |                                                                                                                                                             | 2b. HOUR<br><b>8:00 A</b><br>M                                                            |                                                                                                                            |                                                         |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>White</b>                                                                                                                  |                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 26, 1910</b>                                                                                                  |                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b><br>YRS                                                                        |                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b><br>MD.                                                       |                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3124 Guilford Avenue</b> |                                                           |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Factory Worker</b> |                                                                                                                            | 12b. KIND OF INDUSTRY<br><b>Eastern Venetian Blinds</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>                                                                                                                                                                                                                          |  |                                                                                                                                          |                                                           | 13b. COUNTY<br><b>Balto.</b>                                                                                                                                |                                                                                           | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                         |                                                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Herman Pirkey</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Blanche Cassidy</b>                                                                                     |                                                                                           |                                                                                                                            |                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217 10 1037</b>                                                            |                                                           | 17. INFORMANT<br>ADDRESS<br><b>Kenneth E. Weaver, Same</b>                                                                                                  |                                                                                           |                                                                                                                            |                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                          |                                                           |                                                                                                                                                             |                                                                                           |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                              |  |                                                                                                                                          |                                                           |                                                                                                                                                             |                                                                                           |                                                                                                                            |                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                                                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                        |                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                           |                                                                                                                            |                                                         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                           |                                                                                                                            |                                                         |  |
| 22a. I certify that (this hospital) attended the deceased from <b>5/15</b> , 19 <b>86</b> , to <b>5/17</b> , 19 <b>86</b> , that (we) last saw the deceased alive on <b>3</b> , 19 <b>86</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.   |  |                                                                                                                                          |                                                           |                                                                                                                                                             |                                                                                           |                                                                                                                            |                                                         |  |
| 22b. SIGNATURE<br><b>John W. Bowie MD</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |                                                           | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                           | 22c. DATE SIGNED<br><b>5/17/86</b>                                                                                         |                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. John W. Bowie, MD</b>                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |                                                           | 22e. ADDRESS<br><b>500 W. University Pkwy., Balto., MD</b>                                                                                                  |                                                                                           |                                                                                                                            |                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><b>5/8/86</b>                                                                                                               |                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>                                                                                                    |                                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., MD</b>                                                            |                                                         |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co.<br/>4905 York Road Balto., MD 21212</b>                                                                                                                                                                                                                               |  |                                                                                                                                          |                                                           | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1986</b>                                                                                                          |                                                                                           | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>                                                                        |                                                         |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filed in by the funeral director, pages 3 and 4 should be attached to the burial-transit permit. Then please send this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be called at once.

BP

1

OPTIONAL FORM NO. 10

VERGINI

WE V L

Nov 7, 1933

Parcels

White

Feb. 22, 1910

MD

USA

Baltimore City

Baltimore

214 Gullford Avenue

Factory Worker's Unions

Edna

x

214 Gullford Ave., Baltimore

Shipping

Pinkney

Branches

Carroll

No

214 to 107 Kenneth E. Weaver

Edna



x

Mr. John W. Lewis, Inc.

214 W. University Park, Baltimore, MD

Greenington

Greenington

Baltimore, MD

Harry W. Johnson Co.

New York Post Office, Baltimore, MD 2110

00-06521

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14271  
REG. NO.1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                            |  |  |                                                                                                                                                                                                                                                                                                                                                  |  |  |                                                                                              |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                     |  |  | Frank Webb                                                                                                 |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR                                                                                                                                                                                                                                                          |  |  | 2b. HOUR                                                                                     |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  | 4. RACE                                                                                                    |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR                                                                                                                                                                                                                                                                                                               |  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY                                                           |  |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  | Black                                                                                                      |  |  | 11-01-16                                                                                                                                                                                                                                                                                                                                         |  |  | 69 YRS.                                                                                      |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                               |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                 |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                         |  |  |
| Plymouth, N.C.                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  | USA                                                                                                        |  |  |                                                                                                                                                                                                                                                                                                                                                  |  |  | Baltimore City MD.                                                                           |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                               |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                                                                    |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |  |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  | Cross and Charles Sts.                                                                                     |  |  |                                                                                                                                                                                                                                                                                                                                                  |  |  |                                                                                              |  |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  | 13b. COUNTY                                                                                                |  |  | 13c. CITY OR TOWN                                                                                                                                                                                                                                                                                                                                |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  | Baltimore                                                                                                  |  |  | Baltimore                                                                                                                                                                                                                                                                                                                                        |  |  | 5 South Ellamont Street 21229                                                                |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                              |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                            |  |  | 16b. SOCIAL SECURITY NO.                                                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                            |  |  | Yes                                                                                                                                                                                                                                                                                                                                              |  |  | 1943- 1946                                                                                   |  |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  | ADDRESS                                                                                                    |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ethanolism</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                 |  |  |
| Odessa S. Webb                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  | 5 S. Ellamont St.                                                                                          |  |  |                                                                                                                                                                                                                                                                                                                                                  |  |  |                                                                                              |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                      |  |  |                                                                                                            |  |  |                                                                                                                                                                                                                                                                                                                                                  |  |  |                                                                                              |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                          |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                              |  |  |                                                                                              |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                               |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                 |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                                                                                                                                                                                                                    |  |  |                                                                                              |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                |  |  |                                                                                              |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |                                                                                                            |  |  |                                                                                                                                                                                                                                                                                                                                                  |  |  |                                                                                              |  |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  | TITLE (SPECIFY)                                                                                            |  |  | DATE SIGNED                                                                                                                                                                                                                                                                                                                                      |  |  |                                                                                              |  |  |
| Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  | M.D. Assistant                                                                                             |  |  | 5-7-86                                                                                                                                                                                                                                                                                                                                           |  |  |                                                                                              |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |  |  | ADDRESS                                                                                                    |  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                     |  |  | 23b. DATE                                                                                    |  |  |
| Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  | 111 Penn Street                                                                                            |  |  | Burial                                                                                                                                                                                                                                                                                                                                           |  |  | 05-13-86                                                                                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                            |  |  | ADDRESS                                                                                                    |  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                                                               |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                   |  |  |
| Brown/Thompson F.H.                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  | 1913 W. Baltimore Street                                                                                   |  |  | Crownsville Va. Cem.                                                                                                                                                                                                                                                                                                                             |  |  | Crownsville Maryland                                                                         |  |  |
| 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                           |  |  | 25b. REGISTRAR'S SIGNATURE                                                                                 |  |  | 25c. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                                                    |  |  | 25d. REGISTRAR'S SIGNATURE                                                                   |  |  |
| MAY 14 1986                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |                                                                                                            |  |  |                                                                                                                                                                                                                                                                                                                                                  |  |  |                                                                                              |  |  |

07/84  
25M

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

AS-11



W. B. Smith

REPT NOTED 2/12



0-05562

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8614272

|                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                      |                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                     |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                      | 2b. HOUR                                                                       |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                           |                                                                                                        | MONTH DAY YEAR                                                                                                                                           |                                      | MONTH DAY MIN.                                                                 |  |
| THOMAS Robert WEBB                                                                                                                                                                                                                                                                                                         |                                                                                                        | 05 04 86                                                                                                                                                 |                                      | 1 <sup>20</sup> P.M.                                                           |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                     | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)      | 7. BALTIMORE CITY OR COUNTY OF DEATH                                           |  |
| M                                                                                                                                                                                                                                                                                                                          | W                                                                                                      | MONTH DAY YEAR                                                                                                                                           | 60                                   | BALTIMORE CITY MD                                                              |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                  |                                                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                                                                |  |
| Maryland                                                                                                                                                                                                                                                                                                                   |                                                                                                        | BALTIMORE CITY MD                                                                                                                                        |                                      |                                                                                |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                              |  |
| South Baltimore                                                                                                                                                                                                                                                                                                            | SINAL OF BALTIMORE                                                                                     | Administrator                                                                                                                                            |                                      | Westinghouse                                                                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                               |                                                                                                        | 13b. INSIDE CITY LIMITS?                                                                                                                                 |                                      | 13c. STREET ADDRESS / ZIP CODE                                                 |  |
| 13a. STATE CITY COUNTY                                                                                                                                                                                                                                                                                                     |                                                                                                        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |                                      | 44 Wengate Rd. 21117                                                           |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)                                                                                                                                                                                                                                                                                      |                                                                                                        | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)                                                                                                             |                                      |                                                                                |  |
| Sherman Webb                                                                                                                                                                                                                                                                                                               |                                                                                                        | Mary Hubbard                                                                                                                                             |                                      |                                                                                |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                           |                                                                                                        | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                      | 17. INFORMANT ADDRESS                                                          |  |
| YES                                                                                                                                                                                                                                                                                                                        |                                                                                                        | W. W. II 212-22-5163                                                                                                                                     |                                      | Patricia Webb 44 Wengate Rd. Owings Mills, Md.                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          |                                      |                                                                                |  |
| IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u>                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |                                      |                                                                                |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Isoproterenol arrest</u>                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                      |                                                                                |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pericardial metastasis</u>                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                      |                                                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                      |                                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                     |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                      | 20a. AUTOPSY?                                                                  |  |
|                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                         |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                             |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
|                                                                                                                                                                                                                                                                                                                            |                                                                                                        | P.M. 19                                                                                                                                                  |                                      |                                                                                |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                       |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                      | 21f. LOCATION CITY OR TOWN COUNTY STATE                                        |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                      |                                                                                |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                      |                                                                                |  |
| 22a. SIGNATURE                                                                                                                                                                                                                                                                                                             |                                                                                                        | DEGREE                                                                                                                                                   |                                      | 22c. DATE SIGNED                                                               |  |
| [Signature]                                                                                                                                                                                                                                                                                                                |                                                                                                        | M.D.                                                                                                                                                     |                                      | 5/4/86                                                                         |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                      |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                      |                                                                                |  |
| FRIEDRICH J. VON BOWEN, M.D.                                                                                                                                                                                                                                                                                               |                                                                                                        | SINAL OF BALTIMORE                                                                                                                                       |                                      |                                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                  |                                                                                                        | 23b. DATE                                                                                                                                                |                                      | 23c. NAME OF CEMETERY OR CREMATORY                                             |  |
| BURIAL                                                                                                                                                                                                                                                                                                                     |                                                                                                        | May 7, 1986                                                                                                                                              |                                      | LAKE View Mem. PK.                                                             |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                       |                                                                                                        | 25a. DATE REC'D BY REGISTRAR                                                                                                                             |                                      | 25b. REGISTRAR'S SIGNATURE                                                     |  |
| H. J. Schardt                                                                                                                                                                                                                                                                                                              |                                                                                                        | MAY 5 1986                                                                                                                                               |                                      | [Signature]                                                                    |  |
| ADDRESS                                                                                                                                                                                                                                                                                                                    |                                                                                                        | 25c. REGISTRAR'S SIGNATURE                                                                                                                               |                                      |                                                                                |  |
| Owings Mills, Md.                                                                                                                                                                                                                                                                                                          |                                                                                                        | [Signature]                                                                                                                                              |                                      |                                                                                |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Page 1 and 2 could be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



14. J. Schubert Outside Milk, Ind  
May 5, 1982 Lake View Mem. Pk. 24 Keswick Ave. 11 Ind

Admistrator Westing House  
44 Wendate Sq.  
Hr Pward  
Owings Mills, Md.  
44 Wendate Sq.

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|-------------|-------------|
| Mr Baito    | Grand Mills |
| Zigman      | MCP         |
| W.W.II      | Patricia    |
| 515-55-6183 |             |

~~Baito~~ Wardland

A. 2 N

THOMAS Robert WEBB

06

00-07457

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remember to file this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                    |                                   |                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Dorothy</i>                                                                                                                                                                                                                                                                          |  | FIRST <i>A. L.</i>                                                                                                               |  | MIDDLE <i>W.</i>                                                                                                                                         |  | LAST <i>Weber</i>                                                                            |  | 2a. DATE OF DEATH MONTH <i>5</i> DAY <i>18</i> YEAR <i>1986</i>                                                                    |                                   | 2b. HOUR <i>3:47</i> AM                     |  |
| 3. SEX <i>F</i>                                                                                                                                                                                                                                                                                                             |  | 4. RACE <i>C</i>                                                                                                                 |  | 5. DATE OF BIRTH MONTH <i>9</i> DAY <i>3</i> YEAR <i>1912</i>                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS                                                |  | IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>                                                                                        |                                   | IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>                                                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.                               |  |                                                                                                                                    |                                   |                                             |  |
| 10. CITY OR TOWN OF DEATH <i>Balto.</i>                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Agnes Hospital</i> |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Hat Maker</i>               |  |                                                                                                                                    | 12b. KIND OF BUSINESS OR INDUSTRY |                                             |  |
| 13a. STATE <i>Md.</i>                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY <i>Balto.</i>                                                                                                        |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE <i>Balto., Md. 11 Sanford Ave. #21228</i>                                                           |                                   |                                             |  |
| 14. FATHER'S NAME FIRST <i>Karl</i> MIDDLE <i></i> LAST <i>Weber</i>                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST <i>Lillian</i> MIDDLE <i></i> LAST <i>Spencer</i>                                                 |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  | 16b. SOCIAL SECURITY NO. <i>212-05-9564-A</i>                                                |  | 17. INFORMANT ADDRESS <i>11 Sanford Ave. - Balto., Md. #21228</i>                                                                  |                                   |                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>ADENOCARCINOMA OF THE BREAST, BILATERAL</i>                                                                                                                                                     |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                    |                                   |                                             |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>WITH METASTASES TO LYMPH NODES + BONE</i>                                                                                                                                                                                                                                             |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                    |                                   |                                             |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                    |                                   |                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>RHEUMATOID ARTHRITIS</i>                                                                                                                                                             |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                    |                                   |                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  |                                                                                                                                                          |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |                                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |                                                                                              |  |                                                                                                                                    |                                   |                                             |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                              |  |                                                                                                                                    |                                   |                                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                    |                                   |                                             |  |
| 22b. SIGNATURE <i>Michael Pelczar</i>                                                                                                                                                                                                                                                                                       |  | DEGREE <i>M</i>                                                                                                                  |  | 22c. DATE SIGNED <i>5/18</i>                                                                                                                             |  |                                                                                              |  |                                                                                                                                    |                                   |                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PELCZAR, MICHAEL E</i>                                                                                                                                                                                                                                                             |  | 22e. ADDRESS                                                                                                                     |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                    |                                   |                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>                                                                                                                                                                                                                                                                  |  | 23b. DATE <i>May 19, 1986</i>                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Westview Mem. Pk. Cem.</i>                                                                                         |  | 23d. LOCATION CITY OR TOWN <i>Balto.</i> COUNTY <i>Balto.</i> STATE <i>Md.</i>               |  |                                                                                                                                    |                                   |                                             |  |
| 24. FUNERAL DIRECTOR <i>G. Truman Schwab</i>                                                                                                                                                                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR <i>MAY 23 1986</i>                                                                                 |  | 25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>                                                                                                  |  |                                                                                              |  |                                                                                                                                    |                                   |                                             |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14274  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                           |                                                                                                                                                             |                                                                            |                                                                                      |                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William A. Weber                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                           | 2a. DATE OF DEATH MONTH DAY YEAR<br>5/20/86                                                                                                                 |                                                                            | 2b. HOUR<br>0610A                                                                    |                                                                                    |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4. RACE<br>Cau                                                                                                                            | 5. DATE OF BIRTH MONTH DAY YEAR<br>12/26/49                                                                                                                 |                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>36 YRS.                                           |                                                                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S. A.                                                                                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |                                                                                    |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>carpenter |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>LOCAL GOVT.                                   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. CITY OR TOWN<br>Maryland 21239 BALTIMORE                                                                                                                                                                                                                                                                                       |                                                                                                                                           | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                                                                            | 13e. STREET ADDRESS / ZIP CODE<br>5734 MAPLEHILL RD. 21239                           |                                                                                    |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Edwin NMI Weber                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                           | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Anna Leimkuhler                                                                                               |                                                                            |                                                                                      |                                                                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>yes VIETNAM                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br>215-56-3366                                                                                                                     |                                                                            | 17. INFORMANT ADDRESS<br>Carla Weber 5734 MAPLEHILL RD. 21239                        |                                                                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>hypotension</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute non lymphocytic leukemia</u><br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Granulocytopenia</u> |                                                                                                                                           |                                                                                                                                                             |                                                                            |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day<br>several days<br>2 1/2 yrs |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                            | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                    |
| 21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                            |                                                                                      |                                                                                    |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                           | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                            |                                                                                      |                                                                                    |
| 22a. I certify that (a) this hospital attended the deceased from 5/19, 1986, to 5/20, 1986, that (b) I saw the deceased alive on 5/20, 1986, and that in (c) my opinion death occurred on the date and hour and from the causes stated above. (d) I did not view the body after death.                                                                                                                                                         |                                                                                                                                           |                                                                                                                                                             |                                                                            |                                                                                      |                                                                                    |
| 22b. SIGNATURE<br>Timothy J. Low                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                           | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                            | 22c. DATE SIGNED<br>5/20/86                                                          |                                                                                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>TIMOTHY J. LOW                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                           | 22e. ADDRESS<br>University of Md Hosp 225 Green St Balt 21201                                                                                               |                                                                            |                                                                                      |                                                                                    |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                           | 23b. DATE<br>MAY 22, '86                                                                                                                                    |                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br>WWOODLAWN CEMETERY                             |                                                                                    |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE COUNTY, MD                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                           | 24. FUNERAL DIRECTOR NAME ADDRESS<br>WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD.                                                                               |                                                                            |                                                                                      |                                                                                    |
| 25a. DATE REC'D. BY REGISTRAR<br>MAY 21 1986                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                           | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                                   |                                                                            |                                                                                      |                                                                                    |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and originally filed in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100

2000 DEC 17 10:00 AM  
COMM-FBI



0-07715

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 7 5

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                |                                                                                 |                                                                                                 |                                                                                                                            |                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John M. Webster                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 24 86                         |                                                                                                                                                             |                                                                                | 2b. HOUR<br>8 30 AM                                                             |                                                                                                 |                                                                                                                            |                                                            |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4 RACE<br>White                                                                                                                   |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 4 06                                                                                                              |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS                                       |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                               |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                      |                                                                                                 |                                                                                                                            |                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>312 S. Payson Street |                                                                        |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Upholsterer |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Furniture                                                                             |                                                            |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   | 13b. COUNTY                                                            |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                                                 |                                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br>312 Payson Street, 21223 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry Webster                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Staublitz                                                                                            |                                                                                |                                                                                 |                                                                                                 |                                                                                                                            |                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>705-03-5163 |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>Barbara McElwee, 12 Sanford Avenue, 21228          |                                                                                 |                                                                                                 |                                                                                                                            |                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest seq</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Dissecting</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                |                                                                                 |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 MIN</u><br><u>3 YRS</u>                                              |                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a                                                                                                                                                                                                                                                                            |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                |                                                                                 |                                                                                                 |                                                                                                                            |                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                      |  |                                                                                                                                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                 |                                                                                                 |                                                                                                                            |                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                 |                                                                                                 |                                                                                                                            |                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1967</u> , 19 <u>86</u> , to <u>5/24</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>5/22</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                            |  |                                                                                                                                   |                                                                        |                                                                                                                                                             |                                                                                |                                                                                 |                                                                                                 |                                                                                                                            |                                                            |  |
| 27b. SIGNATURE<br><u>S. Muneses MD</u>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   |                                                                        |                                                                                                                                                             | DEGREE<br>MD                                                                   |                                                                                 | 27c. DATE SIGNED<br><u>5/24/86</u>                                                              |                                                                                                                            |                                                            |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Muneses                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   |                                                                        |                                                                                                                                                             | 27e. ADDRESS<br><u>3721 Potomac St. Balto Maryland</u>                         |                                                                                 |                                                                                                 |                                                                                                                            |                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   | 23b. DATE<br>5/26/86                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery                     |                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |                                                                                                                            |                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc., 4107 Wilkens Ave.                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                   |                                                                        |                                                                                                                                                             | 25a. DATE PREPARED BY REGISTRAR<br>MAY 27 1986                                 |                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                |                                                                                                                            |                                                            |  |



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

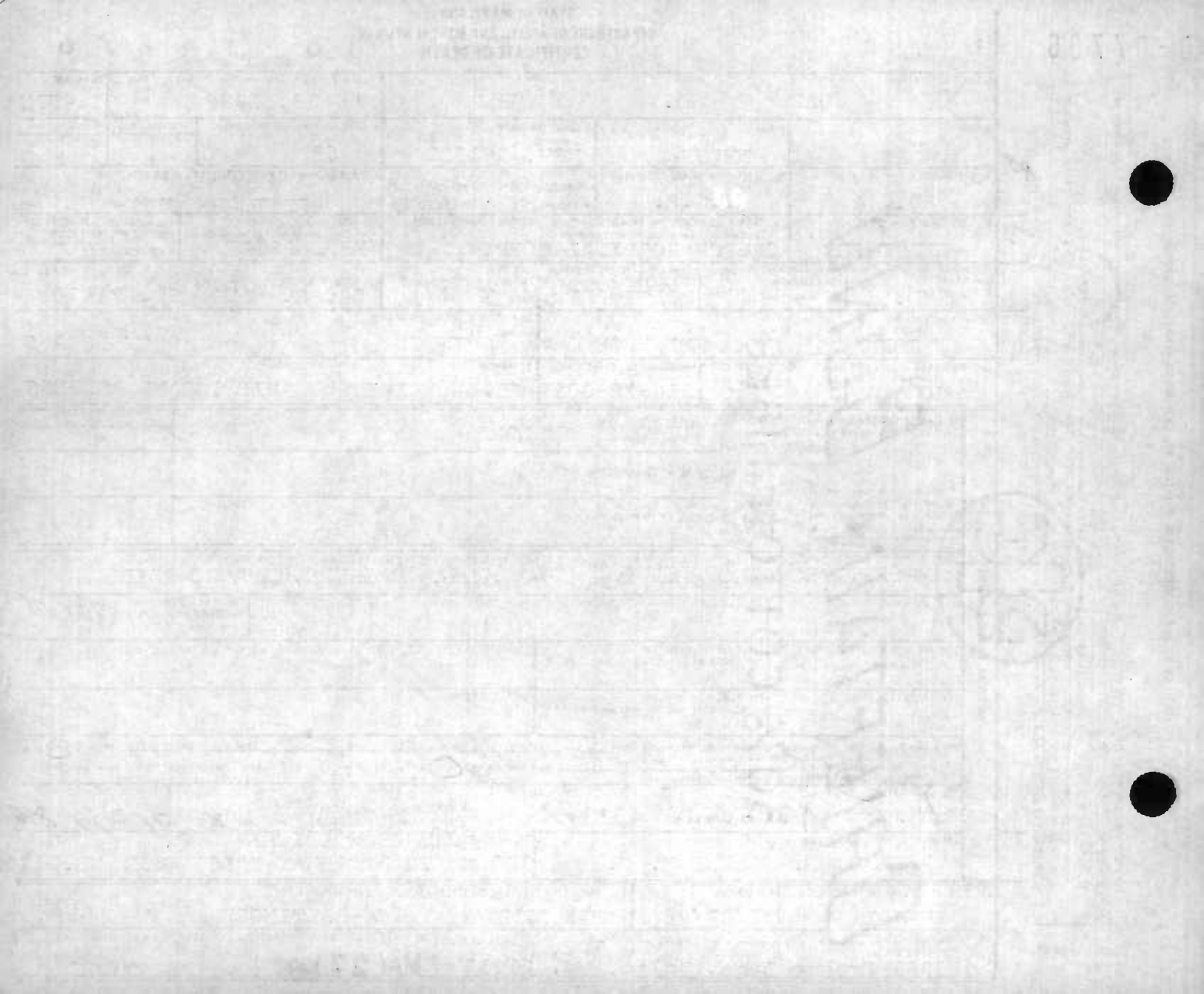
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |                                                            |                                                                                                                                                             |                           |                                                                                                 |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN G. WEININGER</b>                                                                                                                                                                                                                                                                    |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 23, 1986</b> |                                                                                                                                                             | 2b. HOUR<br><b>1:45PM</b> |                                                                                                 |  |                                                                                                                            |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>WHITE</b>                                                                                                                   |                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOV. 3 1922</b>                                                                                                    |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             |                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                               |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL CORP.</b> |                                                            |                                                                                                                                                             |                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>YARDMASTER</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CHESSIE SYSTEM</b>                                                                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                 |  |                                                                                                                                           |                                                            |                                                                                                                                                             |                           |                                                                                                 |  |                                                                                                                            |  |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                           |                                                            | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>800 S. EATON ST. 21224</b>                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN WEININGER</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MINNIE RUCKELSHAUS</b>                                                                                  |                           |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>215-18-3399</b>                                                              |                                                            | 17. INFORMANT ADDRESS<br><b>HELEN WEININGER (WIFE) SAME ADDRESS</b>                                                                                         |                           |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MULTIPLE MYELOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____ |  |                                                                                                                                           |                                                            |                                                                                                                                                             |                           |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>METASTATIC CANCER OF THE COLON, RENAL FAILURE, HEPATIC FAILURE</b>                                                                                                                                             |  |                                                                                                                                           |                                                            |                                                                                                                                                             |                           |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |                                                            |                                                                                                                                                             |                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                |                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                           |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)                                                                        |                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                           |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 14, 1986</b> , to <b>MAY 23, 1986</b> that (I) (we) lost saw the deceased alive on <b>MAY 23, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                   |  |                                                                                                                                           |                                                            |                                                                                                                                                             |                           |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>A. F. Nazemi M.D.</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                           |                                                            |                                                                                                                                                             |                           |                                                                                                 |  | 22c. DATE SIGNED<br><b>5/23/86</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ATAOLLAH F. NAZEMI M. D.</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                           |                                                            | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORP.<br/>100 NORTH BROADWAY BALTIMORE, MD. 2123</b>                                                                     |                           |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>5/27/86</b>                                                                                                               |                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN</b>                                                                                                       |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>                              |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br><b>SCHIMUNEK FUNERAL HOME, INC.<br/>3331 Brehms Lane, Balto. Md. 21213</b>                                                                                                                                                                                                                                                      |  |                                                                                                                                           |                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 27 1986</b>                                                                                                         |                           | 25b. REGISTRAR'S SIGNATURE                                                                      |  |                                                                                                                            |  |

BP



006972

RELEASED AS NON-MEDICAL RECORDS PER MR. GREGORY/DR. RIXON, MEDICAL EXAMINERS

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed, it is to be retained by the funeral director. It is to be completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove contributing papers, pages 1 and 2, and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked as "yes," it is a reportable event, as is any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84

(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MELVIN WEIR</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MAY 16, 1986</b>                                      |  | 2b. HOUR<br><b>5:02</b>                                                                                                    |  |
| 3 SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>B</b>                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 10 28</b>                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.                                            |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                            |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                            |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                         |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>RUTH WEIR</b>                                                                                              |  |                                                                                              |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br><b>212263889</b>                                                                                            |  | 17. INFORMANT ADDRESS<br><b>RUTH MCARTHUR 1018 VALLEY ST.</b>                                                                                               |  |                                                                                              |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardio pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>hypoxia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>pulmonary edema</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>60 min</b><br><b>120 min</b><br><b>4 hours</b> |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                              |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/16</b> , 19 <b>86</b> , to <b>5/16</b> , 19 <b>86</b> , that (I) (we) lost the deceased alive on <b>5/16</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                        |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Michele F. Nowotarski, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |                                                                                              |  | 22c. DATE SIGNED<br><b>5/16/86</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>michele F. Nowotarski</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |  | 22e. ADDRESS<br><b>600 N. Wolfe St Baltimore, MD 21205</b>                                                                                                  |  |                                                                                              |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>5-20-86</b>                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARRISON FOREST</b>                                                                                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>OWING MILLS BALTIMORE MARYLAND</b>             |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR NAME<br><b>WM.C. MARCH F/H INC.</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |  | ADDRESS<br><b>1101 E. NORTH AVE.</b>                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 19 1986</b>                                          |  | 25b. REGISTRAR'S SIGNATURE                                                                                                 |  |

MEDICAL CERTIFICATION

STATE OF NEW YORK  
IN SENATE  
JANUARY 18, 1911  
REPORT OF THE  
COMMISSIONERS OF THE LAND OFFICE

100-100000  
100-100000

JAN 18 1911



Commissioners of the Land Office  
State of New York  
Albany, New York  
January 18, 1911

JAN 18 1911

00-07076

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

14278

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                      |                                                                                                                                                  |                                                                                    |                                                                                                |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE Herbert WELBOURNE</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                      |                                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH <b>05</b> DAY <b>12</b> YEAR <b>86</b>                  |                                                                                                | 2b. HOUR<br><b>11:25 PM</b>                                                                                                |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                     | 4. RACE<br><b>Col</b>                                                                                                                | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>4</b> YEAR <b>97</b>                                                                                   |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>                                                   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                                                           |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>NC</b>                                                                                                                                                                                                                                                                                                                                                                                 | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                              |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>CITY</b>                                                                                                                                                                                                                                                                                                                                                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hosp</b> |                                                                                                                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b> | 12b. KIND OF BUSINESS OR INDUSTRY                                                              |                                                                                                                            |
| 13a. STATE <b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                      | 13b. COUNTY <b>Balto</b>                                                                                                                         | 13c. CITY OR TOWN <b>Balto</b>                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           | 13e. STREET ADDRESS / ZIP CODE<br><b>717 Sturgis Place 21208</b>                                                           |
| 14. FATHER'S NAME<br>FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>                                                                     |                                                                                    |                                                                                                |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br><b>217-03-0193A</b>                                                                                                  |                                                                                    | 17. INFORMANT<br><b>Mrs. Barbara Mitchell</b> ADDRESS <b>717 Sturgis Place 21208</b>           |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>(b) <b>RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>PNEUMONIA</b><br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                      |                                                                                                                                                  |                                                                                    |                                                                                                |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                                                     |                                                                                                                                      |                                                                                                                                                  |                                                                                    |                                                                                                |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                               |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                     |                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                 |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                            |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                           |                                                                                    | 21f. LOCATION<br>STREET <b>05/3</b> CITY OR TOWN <b>05/12</b> COUNTY <b>19</b> STATE <b>86</b> |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>05/12</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I <del>was</del> did) (I <del>did not</del> view the body after death.                                                                                                                                                            |                                                                                                                                      |                                                                                                                                                  |                                                                                    |                                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br><b>Kuang-yen Huang</b>                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                      | DEGREE<br><b>M.D.</b>                                                                                                                            |                                                                                    | 22c. DATE SIGNED<br><b>5/12/86</b>                                                             |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                      | 22e. ADDRESS<br><b>Bon Secours Hospital</b>                                                                                                      |                                                                                    |                                                                                                |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>C</b>                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                      | 23b. DATE<br><b>5/16/86</b>                                                                                                                      |                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>London park</b>                                       |                                                                                                                            |
| 23d. LOCATION<br>CITY OR TOWN <b>Balto</b> COUNTY <b>md</b> STATE                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                      | 24. FUNERAL DIRECTOR<br>NAME <b>Joseph L. Ruess F/A</b> ADDRESS <b>2222 W. York</b>                                                              |                                                                                    |                                                                                                |                                                                                                                            |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 20 1986</b>                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>                                                                                               |                                                                                    |                                                                                                |                                                                                                                            |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2% COTTON SEED

CHILEAN WOOD





00-08116

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 7 9

REG. NO.

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                            |                                                                                                                                                      |                                                                                                                                                             |                                                                 |                                                                                      |                                                                      |                                                                                                                            |                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Jennifer Marie Wenz</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05 26 86</b>                                                                                               |                                                                                                                                                             |                                                                 | 2b. HOUR<br><b>2:30 AM</b>                                                           |                                                                      |                                                                                                                            |                                                                                                 |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>White</b>                                                                                                    |                                                                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05 02 86</b>                                                                                                       |                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>24</b>                     |                                                                      | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN.<br><b>24</b>                                                           |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                 |                                                                                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |                                                                      |                                                                                                                            |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Not MD</b> |                                                                                                                                                      |                                                                                                                                                             |                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>—</b>         |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>                                                                              |                                                                                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                            | 13b. COUNTY<br><b>AA</b>                                                                                                                             |                                                                                                                                                             |                                                                 | 13c. CITY OR TOWN<br><b>Annapolis</b>                                                |                                                                      |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Christopher G. Wenz</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Diane Howlett</b>                                                                                |                                                                                                                                                             |                                                                 | 16. STREET ADDRESS / ZIP CODE<br><b>A-6 Perry Circle 21402</b>                       |                                                                      |                                                                                                                            |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                            | 16b. SOCIAL SECURITY NO.<br><b>—</b>                                                                                                                 |                                                                                                                                                             |                                                                 | 17. INFORMANT<br><b>Christopher Wenz</b>                                             |                                                                      |                                                                                                                            | ADDRESS<br><b>Same as #13</b>                                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Premature cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis Prematurity</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sepsis - (possible) possible DIC, renal insufficiency</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Pulmonary Hemorrhage</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                            |                                                                                                                                                      |                                                                                                                                                             |                                                                 |                                                                                      |                                                                      |                                                                                                                            |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |                                                                                                                                                             |                                                                 | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>PM 19</b>                                                                                      |                                                                                                                                                             |                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                      |                                                                                                                            |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT HOME AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |                                                                                                                                                             |                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                      |                                                                                                                            |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1 AM 5/26 19 86</b> to <b>2:30 PM 5/26 19 86</b> , that (I) (we) lost saw the deceased alive on <b>5/26 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                                    |  |                                                                                                                            |                                                                                                                                                      |                                                                                                                                                             |                                                                 |                                                                                      |                                                                      |                                                                                                                            |                                                                                                 |  |
| 22b. SIGNATURE<br><b>Jo Ellen Estvold</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                            | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                                                                             |                                                                 | 22c. DATE SIGNED<br><b>5/26/86</b>                                                   |                                                                      |                                                                                                                            |                                                                                                 |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. Estvold</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                            | 22c. ADDRESS<br><b>U of MD Hosp</b>                                                                                                                  |                                                                                                                                                             |                                                                 |                                                                                      |                                                                      |                                                                                                                            |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                            | 23b. DATE<br><b>May 28, 1986</b>                                                                                                                     |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>U.S. Naval Academy</b> |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis AA MD</b> |                                                                                                                            |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Taylor Funeral Chapel - Annapolis, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 2 1986</b>                                                                                                   |                                                                                                                                                             |                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Hendall</b>                          |                                                                      |                                                                                                                            |                                                                                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial transit permit. Then please remove carbon of page 1 and 2 and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the attending physician should be notified and page 4 retained.



James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

James M. Smith

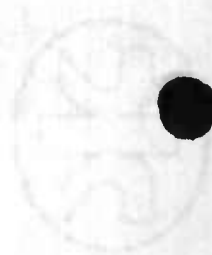
James M. Smith



James M. Smith

James M. Smith

James M. Smith



James M. Smith

James M. Smith

0-07899

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8614280  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                           |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Emil R. Werner                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                           |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 25, 1986                                             |                                                                                | 2b. HOUR<br>M                                                                                                              |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. RACE<br>White                                                                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 21, 1920                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66<br>YRS.                                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna.                                                                                                                                                                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                                                                |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1737 Patapsco St. Balto. Md. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Inspect.               | 12b. KIND OF BUSINESS OR INDUSTRY<br>Liquor Board                              |                                                                                                                            |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                           | 13b. COUNTY<br>Baltimore                                                                                                                                    | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE<br>1737 Patapsco St. Balto. Md. 21230           |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Emil ----- Werner                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Adeline ----- Reynolds                                                                                     |                                                                                                 |                                                                                |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>W.W.2 214-03-5352                                                                               | 17. INFORMANT ADDRESS<br>Mrs. Annetta K. Werner, Same as above                                  |                                                                                |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-respiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Arteriosclerotic cardiac vascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Senescent arteriosclerotic & ischemic myocardium<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 |                                                                                                                                           |                                                                                                                                                             |                                                                                                 |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                      |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 1978, to April 24, 1986, that (I) (we) last saw the deceased alive on April 24, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                        |                                                                                                                                           |                                                                                                                                                             |                                                                                                 |                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br>Romulo V. Goco, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                           | DEGREE<br>M.D.                                                                                                                                              |                                                                                                 | 22c. DATE SIGNED<br>5/27/86                                                    |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Romulo V. Goco, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                           | 22e. ADDRESS<br>5500 Bowlers Lane<br>Baltimore, Md. 21206                                                                                                   |                                                                                                 |                                                                                |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                           | 23b. DATE<br>5/28/1986                                                                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Nem. Park                                      |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. Co. Md.                                                     |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Home, 130 E. Fort Ave.                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                           | Balto. Md. 21230<br>ADDRESS                                                                                                                                 |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>MAY 28 1986                                   |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                           |                                                                                                                                                             |                                                                                                 | 25b. REGISTRAR'S SIGNATURE                                                     |                                                                                                                            |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00870-0



00-05975

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 2 8 1  
REG. NO.1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                              |                                                                                                                                                  |                                                                   |                                                                                      |                                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Ruby Mae Wells                                                                                                                                                                                                                                                                                                              |                                                                                                                              |                                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>05-04-86                   |                                                                                      | 2b. HOUR<br>M                                                                                |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE<br>Black                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05-19-09                                                                                                   |                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76<br>YRS.                                        | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |                                                                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>528 Paca Street |                                                                                                                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                              | 13b. COUNTY<br>Baltimore                                                                                                                         | 13c. CITY OR TOWN<br>Baltimore                                    | 13d. STREET ADDRESS<br>528 Paca Street 21201                                         |                                                                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Allen Williams                                                                                                                                                                                                                                                                                                                                |                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Doshann Simms                                                                                   |                                                                   |                                                                                      |                                                                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                                  |                                                                                                                              | 16b. SOCIAL SECURITY NO.                                                                                                                         |                                                                   | 17. INFORMANT<br>ADDRESS<br>Arrie Wells 528 Paca Street                              |                                                                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cremia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to: immediate cause: (a) stating the underlying cause last<br>(b) <u>End Stage Renal Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Nephrosclerosis</u> |                                                                                                                              |                                                                                                                                                  |                                                                   |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Weeks</u><br><u>Weeks</u><br><u>Years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Congestive Cardiomegaly</u>                                                                                                                                                                                                                  |                                                                                                                              |                                                                                                                                                  |                                                                   |                                                                                      |                                                                                              |
| 19a. DATE OF OPERATION<br><u>N/A</u>                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>N/A</u>                                                                                   |                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                              |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                   |                                                                                                                              | 21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                    |                                                                   |                                                                                      |                                                                                              |
| 21a. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>N/A</u>                                                                                                                                                                                                                                                                                                                           |                                                                                                                              | 21b. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>10</u> <u>85</u> <u>5</u> <u>86</u>                                                      |                                                                   |                                                                                      |                                                                                              |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>5/1</u> <u>86</u> to <u>5</u> <u>86</u> that (I) <del>was</del> last saw the deceased alive on <u>5/1</u> <u>86</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did not</del> view the body after death.                              |                                                                                                                              |                                                                                                                                                  |                                                                   |                                                                                      |                                                                                              |
| 22b. SIGNATURE<br><u>Paul D. Light MD.</u>                                                                                                                                                                                                                                                                                                                                              |                                                                                                                              | DEGREE<br><u>MD.</u>                                                                                                                             |                                                                   | 22c. DATE SIGNED<br><u>5/9/86</u>                                                    |                                                                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>PAUL D. LIGHT</u>                                                                                                                                                                                                                                                                                                                           |                                                                                                                              | 22e. ADDRESS<br><u>22 S. Greene St. Balt. Md. 21201</u>                                                                                          |                                                                   |                                                                                      |                                                                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                     | 23b. DATE<br>05-08-86                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                                                                                        | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |                                                                                      |                                                                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Brown/Thompson F.H. 1913 W. Baltimore Street                                                                                                                                                                                                                                                                                                            |                                                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br>MAY 8 1986                                                                                                      |                                                                   |                                                                                      |                                                                                              |
| 25b. REGISTRAR'S SIGNATURE<br><u>Graham Davidson</u>                                                                                                                                                                                                                                                                                                                                    |                                                                                                                              |                                                                                                                                                  |                                                                   |                                                                                      |                                                                                              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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00-06702

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4 2 8 2

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------|--|----------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------------------------------------|--|---------------------------------------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                               |         | FIRST                        |  | MIDDLE                                                   |  | LAST                                                                                                                                                     |  | 2a. DATE KNOWN OF DEATH                                             |  |                                                   |  | 2b. HOUR                                                            |  |  |  |
| IRVIN                                                                                                                                                                                                                                                                                                                                                                                                                                             |         | HARRISON                     |  | WEST                                                     |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 5 6 19 86                                                                       |  |                                                                     |  | 2b. HOUR<br>5:35 P.M.                             |  |                                                                     |  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE | 5. DATE OF BIRTH             |  | 6. AGE (IN YEARS)                                        |  | IF UNDER 1 YR.                                                                                                                                           |  | IF UNDER 24 HRS.                                                    |  | 2c. DATE PRONOUNCED DEAD                          |  |                                                                     |  |  |  |
| MALE                                                                                                                                                                                                                                                                                                                                                                                                                                              | BLACK   | 1 26 1931                    |  | 55 YRS.                                                  |  |                                                                                                                                                          |  |                                                                     |  | 5 7 19 86                                         |  |                                                                     |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                         |         | 7b. CITIZEN OF WHAT COUNTRY? |  |                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH              |  |                                                                     |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | U. S. A.                     |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  | Baltimore City MD.                                |  |                                                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION                                               |  |                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                              |  | 2786 W. North Ave.                                       |  |                                                                                                                                                          |  | CLAIMS INVESTIGATOR SOC. SEC.                                       |  |                                                   |  | ADMN.                                                               |  |  |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                              |  | 13b. COUNTY                                              |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                               |  |                                                                     |  |  |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                              |  |                                                          |  | BALTIMORE                                                                                                                                                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2786 W. North Avenue<br>Baltimore, Maryland 21216 |  |                                                                     |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                              |  | 15. MOTHER'S MAIDEN NAME                                 |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| Irvin Turner West                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                              |  | Ella Geneva Dorsey                                       |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                                                                                                                                                                                                                                                                      |         |                              |  | 16b. SOCIAL SECURITY NO.                                 |  |                                                                                                                                                          |  | 17. INFORMANT                                                       |  |                                                   |  | ADDRESS                                                             |  |  |  |
| Yes                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                              |  | 218-26-4647                                              |  |                                                                                                                                                          |  | Gloria Johnson                                                      |  |                                                   |  | 4553 Lanier Avenue<br>Baltimore, Maryland 21215                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                         |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| IMMEDIATE CAUSE (a) Multiple stab wounds                                                                                                                                                                                                                                                                                                                                                                                                          |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                    |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:                                                                                                                                                                                                                                                                                                                                                     |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                               |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                            |         |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  | 20. AUTOPSY?                                                        |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS                                                                                                                                                                                                                                                                                                                                                                                                                           |         |                              |  | 21b. TIME OF INJURY                                      |  |                                                                                                                                                          |  | 21c. HOW INJURY OCCURRED                                            |  |                                                   |  |                                                                     |  |  |  |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                            |         |                              |  | HOUR A.M. MONTH DAY YEAR<br>? P.M. 5-6- 19 86            |  |                                                                                                                                                          |  | Subject stabbed.                                                    |  |                                                   |  |                                                                     |  |  |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                              |  | 21e. PLACE OF INJURY                                     |  |                                                                                                                                                          |  | 21f. LOCATION                                                       |  |                                                   |  |                                                                     |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                      |         |                              |  | home                                                     |  |                                                                                                                                                          |  | 2786 W. North Ave., Balto. MD                                       |  |                                                   |  |                                                                     |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| TITLE (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| Assistant MEDICAL EXAMINER                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| DATE SIGNED 5-8-86                                                                                                                                                                                                                                                                                                                                                                                                                                |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                                             |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| ADDRESS 111 Penn St., Balto., MD 21201                                                                                                                                                                                                                                                                                                                                                                                                            |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                         |         |                              |  | 23b. DATE                                                |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  |                                                                     |  | 23d. LOCATION                                     |  |                                                                     |  |  |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                            |         |                              |  | May 14, 1986                                             |  | Garrison Forest Veteran                                                                                                                                  |  |                                                                     |  | Baltimore, Maryland                               |  |                                                                     |  |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| NUTTER & SONS FUNERAL HOME, INC.                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216                                                                                                                                                                                                                                                                                                                                                                                                      |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| MAY 15 1986                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |
| Julia Davidson-Randall                                                                                                                                                                                                                                                                                                                                                                                                                            |         |                              |  |                                                          |  |                                                                                                                                                          |  |                                                                     |  |                                                   |  |                                                                     |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE BLANK SPACE ON THE REVERSE SIDE OF THIS FORM. PAGE 3 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from page 1 and 2 and place them in the envelope with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                |  | REG. NO. 8614283                                                                                                                                            |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Roberta E. Wheeler</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 25 86</b>                                                                                                       |  |                                                                                                                            |  |
| 3 SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                |  | 7b. HOUR<br><b>12<sup>55</sup> AM</b>                                                                                                                       |  |                                                                                                                            |  |
| 4 RACE<br><b>White</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 31 14</b>                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                                                                                                           |  | 7a. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA - Md.</b>                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Worker</b>                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Ft. Holabird</b>                                                                   |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                |  | 13c. CITY OR TOWN<br><b>Edgemere</b>                                                                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Parks</b>                                                                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Beulah Ridenbaugh</b>                                                                      |  | 13e. STREET ADDRESS / ZIP CODE<br><b>Route 10 Box 651 Sparrows Pt 21219</b>                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br><b>220-18-5957</b>                                                                                                 |  | 17. INFORMANT<br><b>Raymond C. Wheeler</b>                                                                                                                  |  | ADDRESS<br><b>Same as 13e</b>                                                                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>G - Pulmonary hepatitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 hour</b><br><b>3 months</b>                                                                          |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                                  |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>5/7/86</b>                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Fever of unknown origin</b>                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/26</b> , 19 <b>86</b> , to <b>5/25</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/25</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>L. Schultheis</b> M.D. Ph.D.<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                               |  |                                                                                                                                                |  | 22c. DATE SIGNED<br><b>5/25/86</b>                                                                                                                          |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. Schultheis</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                |  | 22e. ADDRESS<br><b>Francis Scott Key Hospital</b>                                                                                                           |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>5/28/1986</b>                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge</b>                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dorsey Howard Maryland</b>                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b><br>ADDRESS<br><b>7922 Wise Avenue Dundalk, Maryland 21222</b>                                                                                                                                                                                                                                                                    |  |                                                                                                                                                |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>MAY 28 1986</b>                                                                                                       |  |                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                            |  |                                                                                                                            |  |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                               |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                             |  | REG. NO. 86 14284                                                                                      |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                         |  | 2b. HOUR                                                                                                                |  | A                                                                                                                                                        |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                   |  | FIRST MIDDLE LAST                                                                                      |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                         |  | 2b. HOUR                                                                                                                |  | A                                                                                                                                                        |  |
| Eleanor (ELDNORA)                                                                                                                                  |  | WHITAKER                                                                                               |  | 5-5-86                                                                                                                                                   |  | 4:00                                                                                                                    |  | M                                                                                                                                                        |  |
| 3. SEX                                                                                                                                             |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                         |  | IF UNDER 1 YEAR IF UNDER 24 HRS                                                                                                                          |  |
| F                                                                                                                                                  |  | B                                                                                                      |  | 5 3 12                                                                                                                                                   |  | 74                                                                                                                      |  | YRS. MONTHS DAYS HOURS MIN.                                                                                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                    |  | MD.                                                                                                                                                      |  |
| N.C.                                                                                                                                               |  | USA                                                                                                    |  |                                                                                                                                                          |  | Baltimore                                                                                                               |  |                                                                                                                                                          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |                                                                                                                                                          |  |
| Baltimore                                                                                                                                          |  | Lutheran Hospital                                                                                      |  | Unemployed                                                                                                                                               |  |                                                                                                                         |  |                                                                                                                                                          |  |
| 13a. STATE                                                                                                                                         |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. STREET ADDRESS / ZIP CODE                                                                                          |  |                                                                                                                                                          |  |
| Md                                                                                                                                                 |  |                                                                                                        |  | Baltimore                                                                                                                                                |  | 607 W. Lafayette Ave 21217                                                                                              |  |                                                                                                                                                          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                             |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |  | 16b. SOCIAL SECURITY NO.                                                                                                |  | 17. INFORMANT ADDRESS                                                                                                                                    |  |
| Fletcher                                                                                                                                           |  | Hunter                                                                                                 |  | Jane Branch                                                                                                                                              |  | 246-62-2371                                                                                                             |  | Clandia Conway 1132 Braddish Ave                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)                          |  | DUE TO, OR AS A CONSEQUENCE OF                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |                                                                                                                         |  |                                                                                                                                                          |  |
| Cardiogenic Shock                                                                                                                                  |  | Ischemic Heart Disease                                                                                 |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                                                                                          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                                                         |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                                                                                          |  |
|                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                                                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                |  | COPD. Renal Failure                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                                                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                                                                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                         |  |                                                                                                                                                          |  |
|                                                                                                                                                    |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                                                                                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |                                                                                                                                                          |  |
|                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                                                                                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from                                                                                 |  | A-29 19 86                                                                                             |  | to 5-5 19 86                                                                                                                                             |  | that (I) (we) last saw the deceased alive on 5-5 19 86                                                                  |  | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |
| 22b. SIGNATURE                                                                                                                                     |  | DEGREE                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED                                                                                                        |  |                                                                                                                                                          |  |
| BICH T DUONG                                                                                                                                       |  | M.D.                                                                                                   |  |                                                                                                                                                          |  | 5-5-86                                                                                                                  |  |                                                                                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                              |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                                                                                          |  |
| BICH T DUONG                                                                                                                                       |  | LUTHERAN HOSPITAL                                                                                      |  |                                                                                                                                                          |  |                                                                                                                         |  |                                                                                                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                          |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                 |  |                                                                                                                                                          |  |
| Burial                                                                                                                                             |  | 5/9/86                                                                                                 |  | Eastview Cemetery                                                                                                                                        |  | Baltimore MD                                                                                                            |  |                                                                                                                                                          |  |
| 24. FUNERAL DIRECTOR                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |  |                                                                                                                         |  |                                                                                                                                                          |  |
| March Funeral Home West 4300 Wabash Avenue                                                                                                         |  | MAY 7 1986                                                                                             |  | John Davidson                                                                                                                                            |  |                                                                                                                         |  |                                                                                                                                                          |  |



00-08271

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14285

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-------------------------------------------------------------|--|---------------------------------------------------------------|--|---------------------------------------------------------------------|--|--------------------------------------|--|--------------------------|--|-------|--|-----|--|------|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |         | FIRST                                                       |  | MIDDLE                                                        |  | LAST                                                                |  | 2a. DATE KNOWN OF DEATH              |  | ESTIMATED                |  | MONTH |  | DAY |  | YEAR |  | 2b. HOUR  |  |
| George                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | NMN                                                         |  | White                                                         |  |                                                                     |  | 5/ 30/ 19 86                         |  |                          |  |       |  |     |  |      |  | 10:18 A M |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE | 5. DATE OF BIRTH                                            |  | 6. AGE (IN YEARS)                                             |  | IF UNDER 1 YR.                                                      |  | IF UNDER 24 HRS.                     |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY |  | YEAR |  | 10:18 A M |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                     | White   | Apr 4, 1929                                                 |  | 57 YRS.                                                       |  |                                                                     |  |                                      |  | 5/ 30/ 1986              |  |       |  |     |  |      |  |           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                |         | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED                                                    |  | NEVER MARRIED                                                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                          |  |       |  |     |  |      |  |           |  |
| Pennsylvania                                                                                                                                                                                                                                                                                                                                                                                                                             |         | U.S.A.                                                      |  | WIDOWED                                                       |  | DIVORCED                                                            |  | Baltimore City,                      |  |                          |  |       |  |     |  |      |  | MD        |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                |         | Francis Scott Key Medical Center                            |  | Marine Eng.                                                   |  | Beth Steel                                                          |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                               |         | 13b. COUNTY                                                 |  | 13c. CITY OR TOWN                                             |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                  |  |                          |  |       |  |     |  |      |  |           |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                 |         | Anne Arundel                                                |  | Glen Burnie                                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 304 Broadway Avenue                  |  | 21061                    |  |       |  |     |  |      |  |           |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                        |         | 15. MOTHER'S MAIDEN NAME                                    |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| James                                                                                                                                                                                                                                                                                                                                                                                                                                    |         | Elizabeth                                                   |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  | RAe       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                                                                                                                                                                                                                                                             |         | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT                                                 |  | ADDRESS                                                             |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| Yes                                                                                                                                                                                                                                                                                                                                                                                                                                      |         | Korean                                                      |  | 153.26.2337                                                   |  | Elizabeth P. White (Wife)                                           |  | SAME AS 13                           |  |                          |  |       |  |     |  |      |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                              |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>                                                                                                                                                                                                                                                                                                                                                                       |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                           |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                            |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| (b) _____                                                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                           |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| (c) _____                                                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                             |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                      |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |         | 21b. TIME OF INJURY                                         |  | 21c. HOW INJURY OCCURRED                                      |  | 21d. LOCATION                                                       |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         | HOUR A.M. MONTH DAY YEAR                                    |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2            |  | CITY OR TOWN COUNTY STATE                                           |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         | P.M. 19                                                     |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION                                                 |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                             |  | CITY OR TOWN COUNTY STATE                                     |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| ACTUAL SIGNATURE _____ TITLE (SPECIFY) _____ M.D. Assistant MEDICAL EXAMINER DATE SIGNED 5/31/86                                                                                                                                                                                                                                                                                                                                         |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.                                                                                                                                                                                                                                                                                                                                                           |         |                                                             |  |                                                               |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                |         | 23b. DATE                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY                            |  | 23d. LOCATION                                                       |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | Jun. 3, 1986                                                |  | Glen Haven Mem Park                                           |  | CITY OR TOWN COUNTY STATE                                           |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                             |  |                                                               |  | Glen Burnie, Maryland                                               |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                                |         | 25a. DATE REC'D. BY REGISTRAR                               |  | 25b. REGISTRAR'S SIGNATURE                                    |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |
| Singleton Funeral Home, Glen Burnie, Md.                                                                                                                                                                                                                                                                                                                                                                                                 |         | JUN 3 1986                                                  |  | Julia Davidson-Henderson                                      |  |                                                                     |  |                                      |  |                          |  |       |  |     |  |      |  |           |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE DEATH RECORD. GIVE PAGES 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

07/B4  
25M

BP

DHMH - 17  
(VR A15 ME (5))

00-000000

65035 MOTION PICTURE

UNITED AMERICAN



00-06973

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14286

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     |                                                                                                                                                |                                                             |                                                                                                                                                             |                                                                               |                                                                                                 |                                                     |                                                                                     |                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Herbert White</b>                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>XX</b> 5-13 19 86   |                                                                                                                                                             |                                                                               | 2b. HOUR<br>M                                                                                   |                                                     |                                                                                     |                       |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br><b>B</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 1 55</b>                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>31</b> YRS.           | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                                                                                                                     | IF UNDER 24 HRS.<br>HOURS MIN                                                 | 2c. DATE PRONOUNCED DEAD<br>5-14 19 86                                                          |                                                     |                                                                                     | 2d. HOUR<br>9:02 P. M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                             |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                              |                                                     |                                                                                     |                       |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                            |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1004 N. Carrollton Avenue</b> |                                                             |                                                                                                                                                             |                                                                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>N/A</b>                     |                                                     | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |                       |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                     | 13b. COUNTY                                                                                                                                    |                                                             | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                     | 13e. STREET ADDRESS<br><b>1004 N. CARROLLTON AVE. 21217</b>                         |                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FREDERICK LEE WHITE</b>                                                                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                |                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CORINE JOHNSON</b>                                                                                      |                                                                               |                                                                                                 |                                                     |                                                                                     |                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                       |                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220645871</b>                                                                    |                                                             | 17. INFORMANT ADDRESS<br><b>CORINE WHITE 1004 N. CARROLLTON AVE.</b>                                                                                        |                                                                               |                                                                                                 |                                                     |                                                                                     |                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <b>Asthma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                            |                     |                                                                                                                                                |                                                             |                                                                                                                                                             |                                                                               |                                                                                                 |                                                     |                                                                                     |                       |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                |                                                             |                                                                                                                                                             |                                                                               |                                                                                                 |                                                     |                                                                                     |                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |                     |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                                                                                                                                                             |                                                                               |                                                                                                 |                                                     | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                       |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                                                                                 |                                                     |                                                                                     |                       |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                                                                 |                                                     |                                                                                     |                       |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                     |                                                                                                                                                |                                                             |                                                                                                                                                             |                                                                               |                                                                                                 |                                                     |                                                                                     |                       |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>                                                                                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                | D. Assistant MEDICAL EXAMINER<br>TITLE (SPECIFY)            |                                                                                                                                                             |                                                                               |                                                                                                 |                                                     | DATE SIGNED 5-15-86                                                                 |                       |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>           |                                                                                                                                                             |                                                                               |                                                                                                 |                                                     |                                                                                     |                       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                | 23b. DATE<br><b>5-17-86</b>                                 |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL</b>                       |                                                                                                 |                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ANNE ARUNDEL MARYLAND</b>          |                       |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WM.C.MARCH F/H INC. 1101 EAST NORTH AVENUE</b>                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                |                                                             |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 19 1986</b>                           |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i> |                                                                                     |                       |



87030-00



00-05760

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8614287  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                          |                                                       |                                                                                                                                                                |                                                                           |                                                                                                 |                                                                                                                            |                                                                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) (AKA) <b>Geraldine Whitehead</b><br><b>HELEN GERALDINE WHITEHEAD</b>                                                                                                                                                                                                                                                    |  |                                                                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 2 1986</b> |                                                                                                                                                                |                                                                           | 2b. HOUR<br><b>9:00 A.M.</b>                                                                    |                                                                                                                            |                                                                     |  |
| 3 SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                      |  | 4 RACE<br><b>WHITE</b>                                                                                                                   |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 1, 1928</b>                                                                                                      |                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.                                               |                                                                                                                            | 7. IF UNDER 1 YEAR IF UNDER 74 HRS.<br>MONTHS DAYS HOURS MIN.       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |                                                                                                                            |                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1172 Sargeant Street</b> |                                                       |                                                                                                                                                                |                                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY<br><b>///</b>                                                                                                                |                                                       | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                          |                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br><b>1172 Sargeant Street 21223</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence Creasy</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruth Waldren</b>                                                                                           |                                                                           |                                                                                                 |                                                                                                                            |                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216.20.4066</b>                                                            |                                                       | 17. INFORMANT (Daughter) ADDRESS<br><b>Mary R. Whitehead Same as 13</b>                                                                                        |                                                                           |                                                                                                 |                                                                                                                            |                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Squamous Ca of lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                          |                                                       |                                                                                                                                                                |                                                                           |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 months</b>    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>squamous Ca of lung COPD</b>                                                                                                                                                                                            |  |                                                                                                                                          |                                                       |                                                                                                                                                                |                                                                           |                                                                                                 |                                                                                                                            |                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |                                                       |                                                                                                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                        |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                 |                                                                           |                                                                                                 |                                                                                                                            |                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                           |                                                                                                 |                                                                                                                            |                                                                     |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>7-10</b> 19 <b>85</b> , to <b>5-2</b> 19 <b>86</b> , that (we) lost saw the deceased alive on <b>4-30</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not use the body after death.               |  |                                                                                                                                          |                                                       |                                                                                                                                                                |                                                                           |                                                                                                 |                                                                                                                            |                                                                     |  |
| 22b. SIGNATURE<br><b>Paul E. Gormley</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          |                                                       | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                           |                                                                                                 |                                                                                                                            | 22c. DATE SIGNED<br><b>5/2/86</b>                                   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL E. GORMLEY</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                          |                                                       | 22d. ADDRESS<br><b>900 CAYON AVE BALTO. MD 21229</b>                                                                                                           |                                                                           |                                                                                                 |                                                                                                                            |                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>May 5, 1986</b>                                                                                                          |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Memorial Pk.</b>                                                                                           |                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A A Co. Md.</b>                    |                                                                                                                            |                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>AB Vincent</b> ADDRESS<br><b>SINGLETON FUNERAL HOME GLEN BURNIE, MD. 21061</b>                                                                                                                                                                                                                                              |  |                                                                                                                                          |                                                       | 25a. DATE RECEIVED BY REGISTRAR<br><b>MAY 6 1986</b>                                                                                                           |                                                                           | 25b. DECEASED NAME (PRINT)<br><b>Geraldine Whitehead</b>                                        |                                                                                                                            |                                                                     |  |

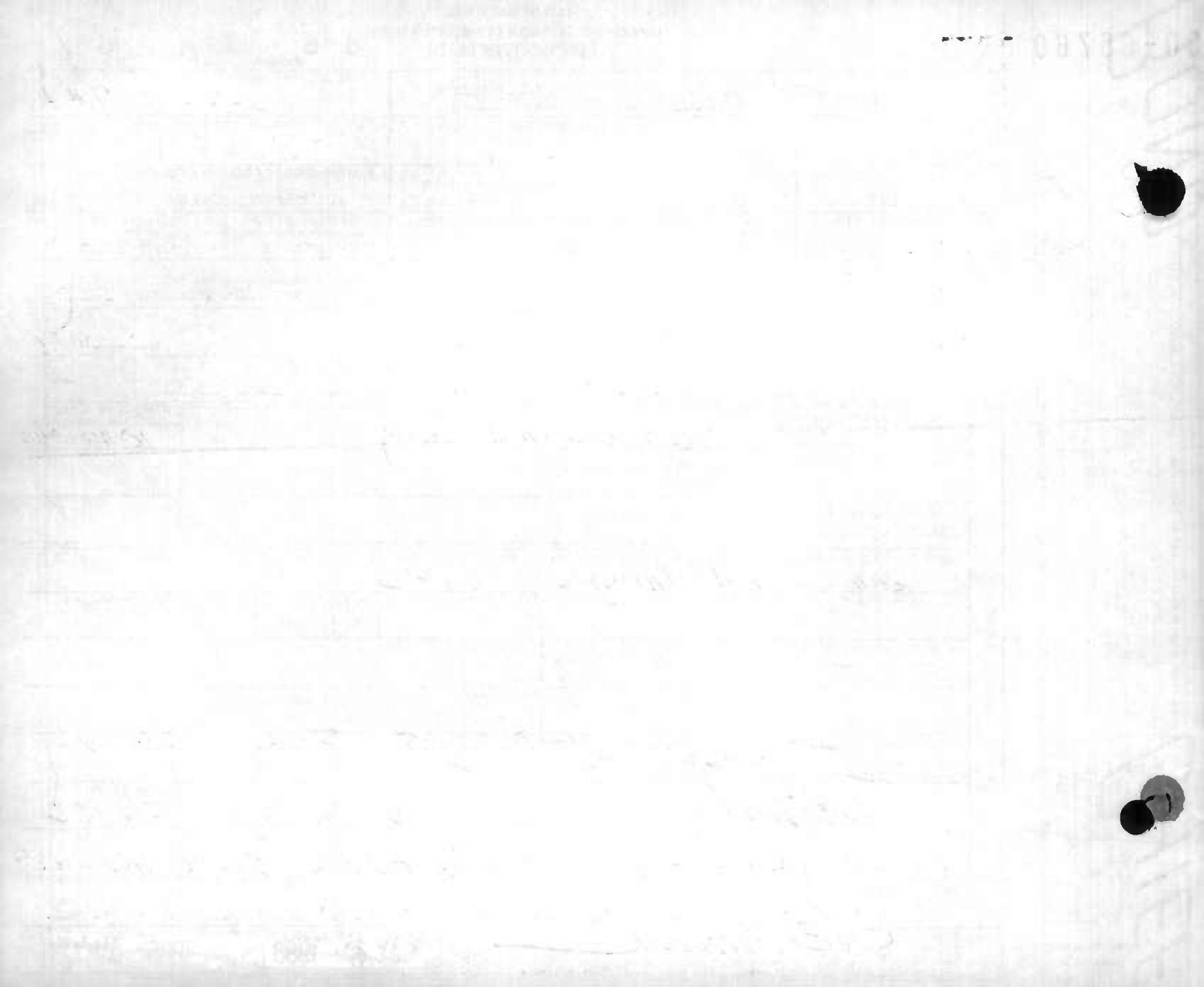
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-08003

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 2 8 8  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                |  |                                                                                                                                                            |                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Olga L. Whitehurst</b>                                                                                                                                                                                                                                                                                                   |  | 2a DATE OF DEATH<br>MONTH <b>5</b> DAY <b>26</b> YEAR <b>1986</b>                                                                                              |  | 2b HOUR<br><b>1030 A</b>                                                                                                                                   |                                                                |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                            |  | 4 RACE<br><b>White</b>                                                                                                                                         |  | 5 DATE OF BIRTH<br>MONTH <b>February</b> DAY <b>7</b> YEAR <b>1911</b>                                                                                     |                                                                |
| 6 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                        |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                |
| 9a CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b>                    |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD                                                                                           |                                                                |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                                                                                                                                                                                                                                               |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                                                            |  |                                                                                                                                                            |                                                                |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                      |  | 13b COUNTY<br><b>Baltimore</b>                                                                                                                                 |  | 13c CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                |
| 14 FATHER'S NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Laukis</b> LAST <b>Unknown</b>                                                                                                                                                                                                                                                                                 |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>                                                                      |  |                                                                                                                                                            |                                                                |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                  |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>212-03-4466</b>                                                                                    |  | 17 INFORMANT<br>ADDRESS <b>Neil Kurlander -922 N. Howard St. - 21201</b>                                                                                   |                                                                |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)                               |  |                                                                                                                                                                |  |                                                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Seconds</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                                                                                                                                                                                                                                   |  |                                                                                                                                                                |  |                                                                                                                                                            |                                                                |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                                |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                      |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |                                                                |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                          |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                          |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                |
| 22a I certify that (I) (this hospital) attended the deceased from <b>5/22</b> , 19 <b>86</b> , to <b>5/26</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>5/26</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                                |  |                                                                                                                                                            |                                                                |
| 22b SIGNATURE<br><b>Gregory S. Barrow</b>                                                                                                                                                                                                                                                                                                                         |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br><b>5/26/86</b>                                                                                                                          |                                                                |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GREGORY S. BARROW</b>                                                                                                                                                                                                                                                                                                  |  | 22e ADDRESS<br><b>Union Memorial Hosp</b>                                                                                                                      |  |                                                                                                                                                            |                                                                |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                   |  | 23b DATE<br><b>5-28-86</b>                                                                                                                                     |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematory</b>                                                                                             |                                                                |
| 23d LOCATION<br>CITY OR TOWN<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                     |  | COUNTY<br><b>Md.</b>                                                                                                                                           |  | STATE                                                                                                                                                      |                                                                |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                              |  | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>                                                                                                              |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAY 29 1986</b>                                                                                                         |                                                                |
| 25b REGISTRAR'S SIGNATURE<br><b>John E. ...</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                |  |                                                                                                                                                            |                                                                |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the attending physician. The law requires that the death certificate be executed with the attending physician.



00-07470

RELEASED AS NON-MED PER DR. SMYTH AND MR. HENRY  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

213-87-432  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed certificate, page 1, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of cause.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                             |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 8 6 1 4 2 8 9<br>REG. NO.                                                                                                                   |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                         |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JAMES WHITTLE</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             |  |                                                                                                                                                            |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>MAY 21, 1986</b>                                                                                     |  | 2b HOUR<br><b>10:49 P M</b>                                                                                             |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4 RACE<br><b>B</b>                                                                                                                          |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8 23 23</b>                                                                                                          |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                                                                                           |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.                                                               |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                    |  |                                                                                                                         |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |                                                                                                                                                            |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CONSTRUCTION</b>                                                        |  | 12b KIND OF BUSINESS OR INDUSTRY                                                                                        |  |
| 13a STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 13b COUNTY<br><b>BALTIMORE</b>                                                                                                              |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                      |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                               |  | 13e STREET ADDRESS / ZIP CODE<br><b>2514 ASHLAND AVENUE 21205</b>                                                       |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>ROBERT WHITE</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>FANNIE PHILLIPS</b>                                                                        |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                         |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES</b>                                                                                                                                                                                                                                                                                                                                             |  | 16b SOCIAL SECURITY NO.<br><b>230189980</b>                                                                                                 |  | 17 INFORMANT ADDRESS<br><b>JOANN WHITTLE 2514 ASHLAND AVENUE</b>                                                                                           |  |                                                                                                                                            |  |                                                                                                                         |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic lung cancer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>1 year</b> |  |                                                                                                                                             |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                             |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |  |                                                                                                                                                            |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                             |  |                                                                                                                                            |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/21/86</b> , 19____, to <b>5/21/86</b> , 19____, that (I) (we) last saw the deceased alive on <b>5/21/86</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                 |  |                                                                                                                                             |  |                                                                                                                                                            |  |                                                                                                                                            |  |                                                                                                                         |  |
| 27a SIGNATURE<br><b>Maney Shapiro</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             |  | DEGREE                                                                                                                                                     |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>5/21/86</b>                                                                                      |  |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             |  | 22b. ADDRESS<br><b>600 N. WOLFE ST. BALTO, MD. 21205</b>                                                                                                   |  |                                                                                                                                            |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br><b>5-27-86</b>                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARRISON FOREST</b>                                                                                               |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>OWING MILLS MD.</b>                                                                          |  |                                                                                                                         |  |
| 24 FUNERAL DIRECTOR NAME<br><b>WM.C.MARCH F/H INC.</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             |  | ADDRESS<br><b>1101 E. NORTH AVENUE</b>                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1986</b>                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                                             |  |

202 203 204



00-07452

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 11b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 4 2 9 0

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                  |                |                                                                                                                                    |  |                                                           |  |                                                                                                                                                             |              |                                                              |  |                                                                                                 |                  |                                                  |                  |                                                   |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|----------------|------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------|------------------|---------------------------------------------------|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                   |  |                  | FIRST<br>Helen |                                                                                                                                    |  | MIDDLE<br>E.                                              |  |                                                                                                                                                             | LAST<br>Whye |                                                              |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 5-22 19 86             |                  |                                                  | 2b. HOUR<br>7:15 |                                                   |  |  |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>Black |                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 31 06                                                                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.                |  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.                                                                                                                  |              | 7c. DATE PRONOUNCED DEAD<br>5-22 19 86                       |  |                                                                                                 | 2d. HOUR<br>7:15 |                                                  |                  |                                                   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                                                                                                                                                                                                                                                                                                     |  |                  |                | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                |  |                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |              |                                                              |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |                  |                                                  |                  |                                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                               |  |                  |                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2629 Loyola Northway |  |                                                           |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |              |                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |                  |                                                  |                  |                                                   |  |  |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                  |                | 13b. COUNTY                                                                                                                        |  |                                                           |  | 13c. CITY OR TOWN<br>Balto.                                                                                                                                 |              |                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  |                                                  |                  | 13e. STREET ADDRESS<br>2629 Loyola Northway 21215 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Daniel Harper                                                                                                                                                                                                                                                                                                                                                                              |  |                  |                |                                                                                                                                    |  |                                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |              |                                                              |  |                                                                                                 |                  |                                                  |                  |                                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                          |  |                  |                | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-18-0815                                                             |  |                                                           |  | 17. INFORMANT<br>ADDRESS<br>Del. Mary B. Adams 2414 W. Lafayette Ave.                                                                                       |              |                                                              |  |                                                                                                 |                  |                                                  |                  |                                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                        |  |                  |                |                                                                                                                                    |  |                                                           |  |                                                                                                                                                             |              |                                                              |  |                                                                                                 |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |                  |                                                   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                  |  |                  |                |                                                                                                                                    |  |                                                           |  |                                                                                                                                                             |              |                                                              |  |                                                                                                 |                  |                                                  |                  |                                                   |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                               |  |                  |                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                  |  |                                                           |  |                                                                                                                                                             |              |                                                              |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                  |                                                  |                  |                                                   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                  |  |                  |                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |  |                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |              |                                                              |  |                                                                                                 |                  |                                                  |                  |                                                   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                               |  |                  |                | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                        |  |                                                           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |              |                                                              |  |                                                                                                 |                  |                                                  |                  |                                                   |  |  |  |
| 22a. I certify that took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |                |                                                                                                                                    |  |                                                           |  |                                                                                                                                                             |              |                                                              |  |                                                                                                 |                  |                                                  |                  |                                                   |  |  |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>                                                                                                                                                                                                                                                                                                                                                                                           |  |                  |                | TITLE (SPECIFY)<br>M.D. Assistant                                                                                                  |  |                                                           |  | MEDICAL EXAMINER                                                                                                                                            |              |                                                              |  | DATE SIGNED<br>5-22-86                                                                          |                  |                                                  |                  |                                                   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                          |  |                  |                | ADDRESS<br>111 Penn St., Balto., Md. 21201                                                                                         |  |                                                           |  |                                                                                                                                                             |              |                                                              |  |                                                                                                 |                  |                                                  |                  |                                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                               |  |                  |                | 23b. DATE<br>5/27/86                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Nat. Cem. |  |                                                                                                                                                             |              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |  |                                                                                                 |                  |                                                  |                  |                                                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H West                                                                                                                                                                                                                                                                                                                                                                                  |  |                  |                |                                                                                                                                    |  |                                                           |  |                                                                                                                                                             |              | ADDRESS<br>4300 Wabash Ave.                                  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 23 1986                                                    |                  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |                  |                                                   |  |  |  |



00-06984

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

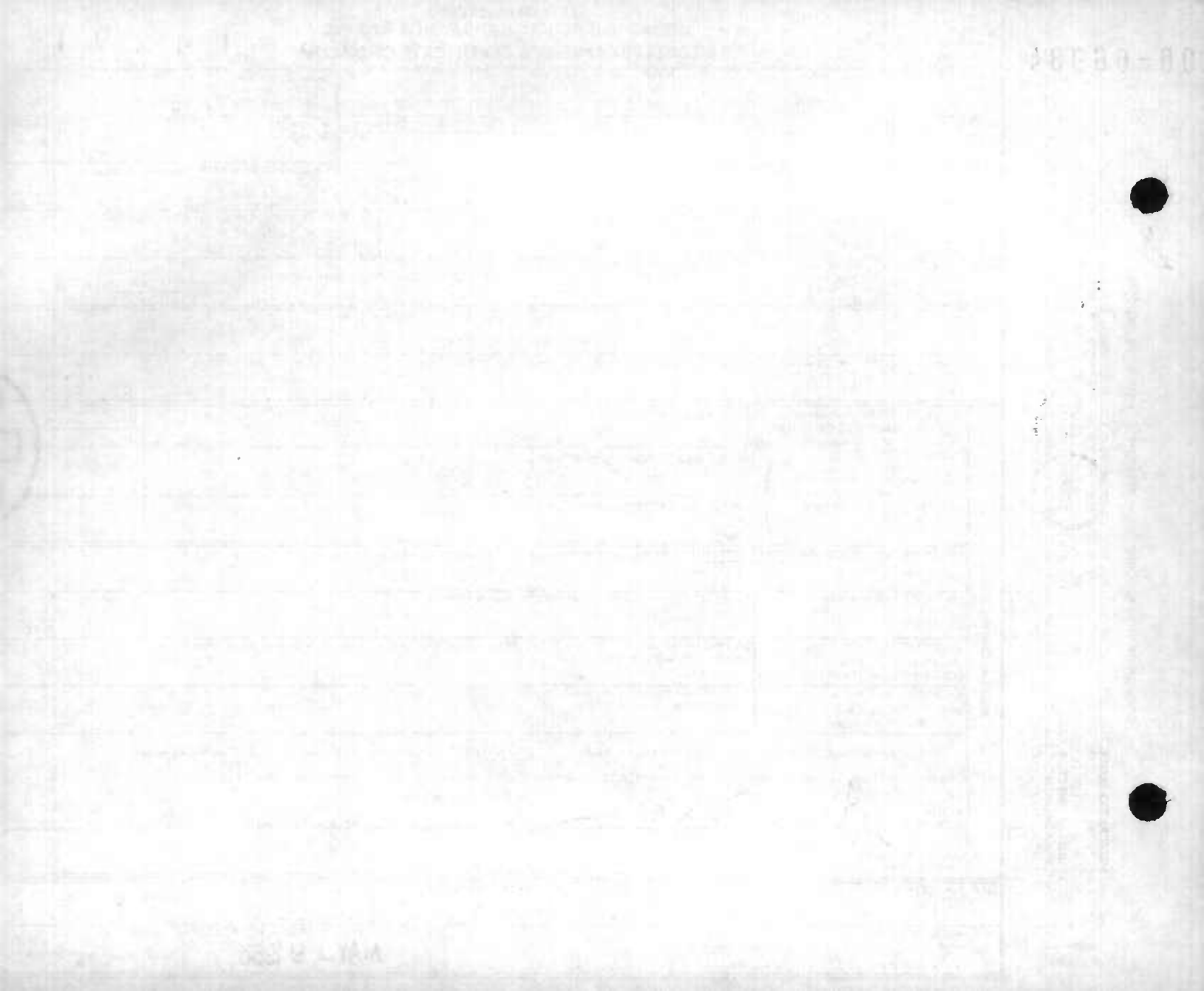
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. THIS PERMIT IS VALID FOR 72 HOURS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14291

|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |           |  |                                                                                                                            |  |                                                        |  |                                                                                                                                                          |  |                                                                                  |  |                                                                            |  |                                                                                              |  |                                                 |  |                                                                                            |  |                    |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------|--|----------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|--------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                           |  |           |  |                                                                                                                            |  |                                                        |  |                                                                                                                                                          |  | 2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 5 9 1986 |  |                                                                            |  |                                                                                              |  |                                                 |  |                                                                                            |  | 2b. HOUR M         |  |
| 1. DECEASED NAME (TYPE OR PRINT) THOMAS WILDER                                                                                                                                                                                                                                                                                                                                                                                                   |  |           |  |                                                                                                                            |  |                                                        |  |                                                                                                                                                          |  | 2c. DATE PRONOUNCED DEAD 5 13 1986                                               |  |                                                                            |  |                                                                                              |  |                                                 |  |                                                                                            |  | 2d. HOUR P M 12:45 |  |
| 3. SEX M                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE B |  | 5. DATE OF BIRTH MONTH DAY YEAR 12 4 32                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.                |  | IF UNDER 1 YR. MONTHS DAYS                                                                                                                               |  | IF UNDER 24 HRS. HOURS MIN                                                       |  |                                                                            |  |                                                                                              |  |                                                 |  |                                                                                            |  |                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.                                                                                                                                                                                                                                                                                                                                                                                                   |  |           |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                        |  |                                                        |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                    |  |                                                                                              |  |                                                 |  |                                                                                            |  |                    |  |
| 10. CITY OR TOWN OF DEATH Baltimore                                                                                                                                                                                                                                                                                                                                                                                                              |  |           |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 617 N. Calhoun St. |  |                                                        |  |                                                                                                                                                          |  |                                                                                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSTRUCTION |  |                                                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY               |  |                                                                                            |  |                    |  |
| 13a. STATE MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                              |  |           |  |                                                                                                                            |  |                                                        |  |                                                                                                                                                          |  | 13b. COUNTY                                                                      |  | 13c. CITY OR TOWN BALTIMORE                                                |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 21217 617 N. CALHOUN STREET |  |                                                                                            |  |                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST HENRY WILDER                                                                                                                                                                                                                                                                                                                                                                                                 |  |           |  |                                                                                                                            |  |                                                        |  |                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE MUZON                          |  |                                                                            |  |                                                                                              |  |                                                 |  |                                                                                            |  |                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO                                                                                                                                                                                                                                                                                                                                                                            |  |           |  | (IF YES, GIVE WAR OR DATES)                                                                                                |  |                                                        |  | 16b. SOCIAL SECURITY NO. N/A                                                                                                                             |  |                                                                                  |  | 17. INFORMANT ADDRESS FRANKLIN WILDER RT. 1 BOX 628 ST. STEPHEN S.C.       |  |                                                                                              |  |                                                 |  |                                                                                            |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive &amp; arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |           |  |                                                                                                                            |  |                                                        |  |                                                                                                                                                          |  |                                                                                  |  |                                                                            |  |                                                                                              |  |                                                 |  |                                                                                            |  |                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.                                                                                                                                                                                                                                                                                                                |  |           |  |                                                                                                                            |  |                                                        |  |                                                                                                                                                          |  |                                                                                  |  |                                                                            |  |                                                                                              |  |                                                 |  |                                                                                            |  |                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                           |  |           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                          |  |                                                        |  |                                                                                                                                                          |  |                                                                                  |  |                                                                            |  |                                                                                              |  |                                                 |  | 20. AUTOPSY? Head Only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                              |  |           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                       |  |                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                                                                                  |  |                                                                            |  |                                                                                              |  |                                                 |  |                                                                                            |  |                    |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                           |  |           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                |  |                                                        |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                  |  |                                                                            |  |                                                                                              |  |                                                 |  |                                                                                            |  |                    |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>            |  |           |  |                                                                                                                            |  |                                                        |  |                                                                                                                                                          |  |                                                                                  |  |                                                                            |  |                                                                                              |  |                                                 |  |                                                                                            |  |                    |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |           |  | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER                                                                            |  |                                                        |  |                                                                                                                                                          |  |                                                                                  |  |                                                                            |  | DATE SIGNED 5-14-86                                                                          |  |                                                 |  |                                                                                            |  |                    |  |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                               |  |           |  | ADDRESS 111 Penn St., Balto., MD 21201                                                                                     |  |                                                        |  |                                                                                                                                                          |  |                                                                                  |  |                                                                            |  |                                                                                              |  |                                                 |  |                                                                                            |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL                                                                                                                                                                                                                                                                                                                                                                                                 |  |           |  | 23b. DATE 5-17-86                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY ST. STEPHENS CHURCH |  |                                                                                                                                                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE CHARLESTON S.C.                          |  |                                                                            |  |                                                                                              |  |                                                 |  |                                                                                            |  |                    |  |
| 24. FUNERAL DIRECTOR NAME WM.C. MARCH F/H INC. 1101 EAST NORTH AVENUE                                                                                                                                                                                                                                                                                                                                                                            |  |           |  |                                                                                                                            |  |                                                        |  |                                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR MAY 19 1986                                        |  | 25b. REGISTRAR'S SIGNATURE                                                 |  |                                                                                              |  |                                                 |  |                                                                                            |  |                    |  |

07/B4  
25MBP  
DHMH - 17  
(VR A15 ME (5))



00-06124

FOR  
1- STATE  
REGISTRAR  
Item 4 A.L.  
5-13-86  
per phoneSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 14292  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                            |                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Luville                                                                                                                                                                                                                                                                                                                               |  | FIRST MIDDLE LAST<br>Wilkins                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 9 86                                                                                                               |  | 2b. HOUR<br>4:49 am                                                                                                        |                                                               |
| 3. SEX<br>female                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>BLACK                                                                                                         |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 18 17                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69<br>YRS                                                                               |                                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto city MD                                                                      |                                                               |
| 10. CITY OR TOWN OF DEATH<br>Balto                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hosp. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                               |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY                                                                                                              |  | 13c. CITY OR TOWN<br>Balto.                                                                                                                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Goodrum                                                                                                                                                                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maggie Spencer                                                          |  | 13e. STREET ADDRESS / ZIP CODE<br>5619 Wayne Ave. 21207                                                                                                     |  |                                                                                                                            |                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-18-2257                                                   |  | 17. INFORMANT<br>ADDRESS<br>Tyla Wilkins 5619 Waynw Ave. Husband                                                                                            |  |                                                                                                                            |                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Resp. arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cardiac failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Sepsis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 mins</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>no</u>                                                                                                                                                                                                                                   |  |                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                            |                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                            |                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NO! WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                   |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE                                                                                                  |  |                                                                                                                            |                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                                                  |  |                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                            |                                                               |
| 22b. SIGNATURE<br><u>Eric Weiner</u>                                                                                                                                                                                                                                                                                                                                         |  | DEGREE<br><u>MD</u>                                                                                                      |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>5/9/86</u>                                                                                          |                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Dr Eric Weiner</u>                                                                                                                                                                                                                                                                                                               |  | 22e. ADDRESS<br><u>Sinai Hosp of Balto</u>                                                                               |  |                                                                                                                                                             |  |                                                                                                                            |                                                               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><u>5/14/86</u>                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arbutus Mem. Park</u>                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br><u>Balto. Md.</u>                                                      |                                                               |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>C. Wainwright</u>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                          |  | ADDRESS<br><u>2700 Edmondson Ave</u>                                                                                                                        |  | 25a. DATE REC'D BY REGISTRAR<br><u>MAY 09 1986</u>                                                                         |                                                               |
| 25b. REGISTRAR'S SIGNATURE<br><u>Jake Davidson-Randall</u>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                            |                                                               |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

20% COTTON FIBRE

WIND  
WINTER  
2



10-02154

00-06497

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14293

REG. NO.

|                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                          |                                                           |                                                                                                                     |                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Hettie Hovington Wilkinson</b>                                                                                                                                                                                                                   |  |                                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 9, 1986</b> |                                                                                                                     | 2b. HOUR<br><b>7 P. M.</b> |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                          |  | 4 RACE<br><b>White</b>                                                                                                                                   |                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 02 1886</b>                                                             |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>99</b>                                                                                                                                                                                                                                                                    |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mardela Springs, Maryland</b>                                                                            |                                                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                       |                            |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                                        |                                                           |                                                                                                                     |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Garden Village Nursing Home</b>          |                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                |                            |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                               |  | 13a. STREET ADDRESS / ZIP CODE<br><b>2202 Walshire Avenue 21234</b>                                                                                      |                                                           |                                                                                                                     |                            |  |
| 13b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                 |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                    |                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Rush Venables</b>                                                                                                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nancy Ellen Bradley</b>                                                                              |                                                           |                                                                                                                     |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-54-3974</b>                                                                            |                                                           | 17. INFORMANT<br>ADDRESS<br><b>Katherine W. Elliott (Daughter)<br/>2601 Putty Hill Avenue, Baltimore, Md. 21234</b> |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Upper respiratory infection</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Organic brain sd</b> |  |                                                                                                                                                          |                                                           |                                                                                                                     |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                              |  |                                                                                                                                                          |                                                           |                                                                                                                     |                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                           |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |                                                           |                                                                                                                     |                            |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |                                                           |                                                                                                                     |                            |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/><br>AT WORK                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/22/86</b> to <b>5/9/86</b> , that (I) (we) saw the deceased alive on <b>4/22/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)   |  |                                                                                                                                                          |                                                           |                                                                                                                     |                            |  |
| 22b. SIGNATURE<br><b>Vuong Nguyen M.B.</b>                                                                                                                                                                                                                                                                      |  | 22c. DATE SIGNED<br><b>5/10/86</b>                                                                                                                       |                                                           | 22d. ADDRESS<br><b>6331 Belair Road, Baltimore, Md.</b>                                                             |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>5/12/1986</b>                                                                                                                            |                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mardela Cemetery</b>                                                       |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Mardela Springs, Wicomico, Maryland</b>                                                                                                                                                                                                                        |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Holloway Funeral Home, P.A., Salisbury, Maryland</b>                                                          |                                                           |                                                                                                                     |                            |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 14 1986</b>                                                                                                                                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                         |                                                           |                                                                                                                     |                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their please remove completed pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified of case.



95

RECEIVED

100-200000

100-200000

100-200000

8

00-03384

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                        |  |                                                                                                                                  |  |                                                                                                                                                            |                                                             |                                                                                                |                    |                                                                                                                           |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------|---------------------------------------------------------------------------------------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  |  |                                                                                                                                                            |                                                             |                                                                                                |                    |                                                                                                                           |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>BISHOP Charlie VS. Charles T. WXX Wilks Sr.                                                                                                                                                                                                                                                                                              |  |                                                                                                                                  |  |                                                                                                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>4 7 86                |                                                                                                | 2b HOUR<br>2 38 AM |                                                                                                                           |  |
| 3 SEX<br>M                                                                                                                                                                                                                                                                                                                                                                  |  | 4 RACE<br>B                                                                                                                      |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>2 20 23                                                                                                               |                                                             | 6 AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.                                                      |                    | 7 IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                          |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.                                                                                                                                                                                                                                                                                                                            |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                            |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                             | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |                    |                                                                                                                           |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                       |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |  |                                                                                                                                                            |                                                             | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BETH. STEEL                    |                    | 12b KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                     |  |                                                                                                                                  |  |                                                                                                                                                            |                                                             |                                                                                                |                    |                                                                                                                           |  |
| 13a STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                       |  | 13b COUNTY                                                                                                                       |  | 13c CITY OR TOWN<br>BALTIMORE                                                                                                                              |                                                             | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                    |                                                                                                                           |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>DAVID WILKS                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                  |  |                                                                                                                                                            | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FLORA SLADE |                                                                                                |                    |                                                                                                                           |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                      |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>219-10-2560                                                             |  | 17 INFORMANT ADDRESS<br>EMMA F. WILKS 1423 E. FEDERAL STREET                                                                                               |                                                             |                                                                                                |                    |                                                                                                                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Anterior Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                  |  |                                                                                                                                                            |                                                             |                                                                                                |                    |                                                                                                                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                          |  |                                                                                                                                  |  |                                                                                                                                                            |                                                             |                                                                                                |                    |                                                                                                                           |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                       |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  |                                                                                                                                                            |                                                             | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                    | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |                                                             |                                                                                                |                    |                                                                                                                           |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                 |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                             |                                                                                                |                    |                                                                                                                           |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>4/7</u> 19 <u>86</u> , to <u>4/7</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/7</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.                        |  |                                                                                                                                  |  |                                                                                                                                                            |                                                             |                                                                                                |                    |                                                                                                                           |  |
| 22b SIGNATURE<br><u>Paul Marinelli</u> M.D.                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  |  | 22c DATE SIGNED<br>4/7/86                                                                                                                                  |                                                             |                                                                                                |                    |                                                                                                                           |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Paul Marinelli, M.D.                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                  |  | 22e ADDRESS<br>Union Memorial Hospital                                                                                                                     |                                                             |                                                                                                |                    |                                                                                                                           |  |
| 23a BURIAL, CREMATION, REMOVAL<br>BURIAL                                                                                                                                                                                                                                                                                                                                    |  | 23b DATE<br>4-12-86                                                                                                              |  | 23c NAME OF CEMETERY OR CREMATORY<br>WOODLAWN                                                                                                              |                                                             | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>WOODLAWN MARYLAND                                 |                    |                                                                                                                           |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>WM.C.MARCH F/H INC. 1101 E.NORTH AVE.                                                                                                                                                                                                                                                                                                |  |                                                                                                                                  |  |                                                                                                                                                            |                                                             | 25a DATE REC'D BY REGISTRAR<br>APR 11 1986                                                     |                    | 25b REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>                                                                |  |

6010

University of Chicago

00-06054

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 9 5  
REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |                                                                                   |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                 |                                                                                                                                       |                                                                   |                                                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ethel E. Willem</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 8 1986</b>                          |                                                                                                                                                             |                                                                                      | 2b. HOUR<br><b>12:30PM</b>                                                                                                                 |                                                                                                 |                                                                                                                                       |                                                                   |                                                  |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>White</b>                                                                                                               |                                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 30, 1911</b>                                                                                                |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                                                                                          |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                             |                                                                   |                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                         |                                                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                          |                                                                                                 |                                                                                                                                       |                                                                   |                                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3501 Rosekemp Ave</b> |                                                                                   |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                                       |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                     |                                                                   |                                                  |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                       | 13b. COUNTY<br><b>Baltimore</b>                                                   |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                       | 13e. STREET ADDRESS / ZIP CODE<br><b>3501 Rosekemp Ave. 21214</b> |                                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wilmer P. Wheat</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Walbert</b>                   |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                 |                                                                                                                                       |                                                                   |                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br><b>217-07-8755</b>                                    |                                                                                                                                                             | 17. INFORMANT ADDRESS<br><b>Mr. Kurt S. Willem 3116 Harford Rd. Hydes, Md. 21082</b> |                                                                                                                                            |                                                                                                 |                                                                                                                                       |                                                                   |                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)                                 |  |                                                                                                                                       |                                                                                   |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                 |                                                                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |                                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                             |  |                                                                                                                                       |                                                                                   |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                 |                                                                                                                                       |                                                                   |                                                  |  |
| 19a. DATE OF OPERATION<br><b>1/9/86</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Bronchogenic Carcinoma</b> |                                                                                                                                                             |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                   |                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     |  |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                 |                                                                                                                                                             |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                 |                                                                                                                                       |                                                                   |                                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                    |  |                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |                                                                                                                                                             |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                 |                                                                                                                                       |                                                                   |                                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 5</b> , 19 <b>85</b> , to <b>May 7</b> , 19 <b>86</b> that (I) (we) lost<br>saw the deceased alive on <b>April 25</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                       |                                                                                   |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                 |                                                                                                                                       |                                                                   |                                                  |  |
| 22b. SIGNATURE<br><b>Stephen R. Selinger</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       | DEGREE<br><b>MD</b>                                                               |                                                                                                                                                             |                                                                                      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 |                                                                                                                                       | 22c. DATE SIGNED<br><b>5/8/86</b>                                 |                                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEPHEN R. SELINGER</b>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       | 22e. ADDRESS<br><b>600 N WIFE ST BALTIMORE MD 21205</b>                           |                                                                                                                                                             |                                                                                      |                                                                                                                                            |                                                                                                 |                                                                                                                                       |                                                                   |                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       | 23b. DATE<br><b>5-9-86</b>                                                        |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview</b>                                |                                                                                                                                            |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                                                              |                                                                   |                                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |                                                                                   |                                                                                                                                                             |                                                                                      | ADDRESS<br><b>5305 Harford Rd.</b>                                                                                                         |                                                                                                 | 25a. DATE RECD. BY REGISTRAR<br><b>MAY 9 1986</b>                                                                                     |                                                                   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the detached page to the funeral director. Page 1 and 2 should be filed with a 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other terminal condition, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    |  |                                                                                                                                                             |                                                                                                 |                                                                                 |                                                                |                                                                            |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                    |  | REG. NO. 86 14296                                                                                                                  |  |                                                                                                                                                             |                                                                                                 |                                                                                 |                                                                |                                                                            |  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Ambrose A. William</i>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>5 31 86</i>                                              |                                                                                 |                                                                | 2b. HOUR<br><i>M</i>                                                       |  |                                                                                                                            |  |
| 3 SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                      |  | 4 RACE<br><i>White</i>                                                                                                             |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>12 24 14</i>                                                                                                          |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>71</i> YRS.                               |                                                                | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                 |  |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.               |                                                                |                                                                            |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>VA Medical Center</i> |  |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i> |                                                                | 12b. KIND OF BUSINESS OR INDUSTRY                                          |  |                                                                                                                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |  |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                 | 13e. STREET ADDRESS / ZIP CODE<br><i>Wellington Ave. 21211</i> |                                                                            |  |                                                                                                                            |  |
| 13a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br><i>--</i>                                                                                                           |  | 13c. CITY OR TOWN<br><i>Baltimore</i>                                                                                                                       |                                                                                                 |                                                                                 |                                                                |                                                                            |  |                                                                                                                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Wilbert U. Ambrose</i>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Ida Lindman</i>                                                                                            |                                                                                                 |                                                                                 |                                                                |                                                                            |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>yes</i>                                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><i>WW II 220-07-0630</i>                                                                               |  | 17. INFORMANT ADDRESS<br><i>Genevieve Ambrose 3438 Roland Ave. 21211</i>                                                                                    |                                                                                                 |                                                                                 |                                                                |                                                                            |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CARDIOPULMONARY ARREST</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>SQUAMOUS &amp; TRANSITION CELL CANCER</i><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                    |  |                                                                                                                                                             |                                                                                                 |                                                                                 |                                                                |                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>MINUTES</i>                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                        |  |                                                                                                                                    |  |                                                                                                                                                             |                                                                                                 |                                                                                 |                                                                |                                                                            |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 |                                                                                 |                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                     |  |                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                                              |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                                                |                                                                            |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                          |                                                                                                 | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                  |                                                                |                                                                            |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                               |  |                                                                                                                                    |  |                                                                                                                                                             |                                                                                                 |                                                                                 |                                                                |                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE <i>[Signature]</i> M.D.                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                                             |                                                                                                 | DEGREE                                                                          |                                                                | 22c. DATE SIGNED<br><i>5/31/86</i>                                         |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>STEPHEN P. YOUNG, M.D.</i>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                                             |                                                                                                 | 22e. ADDRESS<br><i>3900 Loch Raven Blvd Balto Md 21218</i>                      |                                                                |                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |  | 23b. DATE<br><i>6/4/86</i>                                                                                                                                  |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Md. Veterans Cemetery</i>              |                                                                | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Garrison Forest Maryland</i> |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR NAME<br><i>A. Alan Seitz, Jr.</i>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                                             |                                                                                                 | ADDRESS<br><i>3818 Roland Ave. 21211</i>                                        |                                                                | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 2 1986</i>                         |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                           |  |

| No. |     | Name |     | Origin |     | Date |     | Remarks |     |
|-----|-----|------|-----|--------|-----|------|-----|---------|-----|
| 1   | 1   | 1    | 1   | 1      | 1   | 1    | 1   | 1       | 1   |
| 2   | 2   | 2    | 2   | 2      | 2   | 2    | 2   | 2       | 2   |
| 3   | 3   | 3    | 3   | 3      | 3   | 3    | 3   | 3       | 3   |
| 4   | 4   | 4    | 4   | 4      | 4   | 4    | 4   | 4       | 4   |
| 5   | 5   | 5    | 5   | 5      | 5   | 5    | 5   | 5       | 5   |
| 6   | 6   | 6    | 6   | 6      | 6   | 6    | 6   | 6       | 6   |
| 7   | 7   | 7    | 7   | 7      | 7   | 7    | 7   | 7       | 7   |
| 8   | 8   | 8    | 8   | 8      | 8   | 8    | 8   | 8       | 8   |
| 9   | 9   | 9    | 9   | 9      | 9   | 9    | 9   | 9       | 9   |
| 10  | 10  | 10   | 10  | 10     | 10  | 10   | 10  | 10      | 10  |
| 11  | 11  | 11   | 11  | 11     | 11  | 11   | 11  | 11      | 11  |
| 12  | 12  | 12   | 12  | 12     | 12  | 12   | 12  | 12      | 12  |
| 13  | 13  | 13   | 13  | 13     | 13  | 13   | 13  | 13      | 13  |
| 14  | 14  | 14   | 14  | 14     | 14  | 14   | 14  | 14      | 14  |
| 15  | 15  | 15   | 15  | 15     | 15  | 15   | 15  | 15      | 15  |
| 16  | 16  | 16   | 16  | 16     | 16  | 16   | 16  | 16      | 16  |
| 17  | 17  | 17   | 17  | 17     | 17  | 17   | 17  | 17      | 17  |
| 18  | 18  | 18   | 18  | 18     | 18  | 18   | 18  | 18      | 18  |
| 19  | 19  | 19   | 19  | 19     | 19  | 19   | 19  | 19      | 19  |
| 20  | 20  | 20   | 20  | 20     | 20  | 20   | 20  | 20      | 20  |
| 21  | 21  | 21   | 21  | 21     | 21  | 21   | 21  | 21      | 21  |
| 22  | 22  | 22   | 22  | 22     | 22  | 22   | 22  | 22      | 22  |
| 23  | 23  | 23   | 23  | 23     | 23  | 23   | 23  | 23      | 23  |
| 24  | 24  | 24   | 24  | 24     | 24  | 24   | 24  | 24      | 24  |
| 25  | 25  | 25   | 25  | 25     | 25  | 25   | 25  | 25      | 25  |
| 26  | 26  | 26   | 26  | 26     | 26  | 26   | 26  | 26      | 26  |
| 27  | 27  | 27   | 27  | 27     | 27  | 27   | 27  | 27      | 27  |
| 28  | 28  | 28   | 28  | 28     | 28  | 28   | 28  | 28      | 28  |
| 29  | 29  | 29   | 29  | 29     | 29  | 29   | 29  | 29      | 29  |
| 30  | 30  | 30   | 30  | 30     | 30  | 30   | 30  | 30      | 30  |
| 31  | 31  | 31   | 31  | 31     | 31  | 31   | 31  | 31      | 31  |
| 32  | 32  | 32   | 32  | 32     | 32  | 32   | 32  | 32      | 32  |
| 33  | 33  | 33   | 33  | 33     | 33  | 33   | 33  | 33      | 33  |
| 34  | 34  | 34   | 34  | 34     | 34  | 34   | 34  | 34      | 34  |
| 35  | 35  | 35   | 35  | 35     | 35  | 35   | 35  | 35      | 35  |
| 36  | 36  | 36   | 36  | 36     | 36  | 36   | 36  | 36      | 36  |
| 37  | 37  | 37   | 37  | 37     | 37  | 37   | 37  | 37      | 37  |
| 38  | 38  | 38   | 38  | 38     | 38  | 38   | 38  | 38      | 38  |
| 39  | 39  | 39   | 39  | 39     | 39  | 39   | 39  | 39      | 39  |
| 40  | 40  | 40   | 40  | 40     | 40  | 40   | 40  | 40      | 40  |
| 41  | 41  | 41   | 41  | 41     | 41  | 41   | 41  | 41      | 41  |
| 42  | 42  | 42   | 42  | 42     | 42  | 42   | 42  | 42      | 42  |
| 43  | 43  | 43   | 43  | 43     | 43  | 43   | 43  | 43      | 43  |
| 44  | 44  | 44   | 44  | 44     | 44  | 44   | 44  | 44      | 44  |
| 45  | 45  | 45   | 45  | 45     | 45  | 45   | 45  | 45      | 45  |
| 46  | 46  | 46   | 46  | 46     | 46  | 46   | 46  | 46      | 46  |
| 47  | 47  | 47   | 47  | 47     | 47  | 47   | 47  | 47      | 47  |
| 48  | 48  | 48   | 48  | 48     | 48  | 48   | 48  | 48      | 48  |
| 49  | 49  | 49   | 49  | 49     | 49  | 49   | 49  | 49      | 49  |
| 50  | 50  | 50   | 50  | 50     | 50  | 50   | 50  | 50      | 50  |
| 51  | 51  | 51   | 51  | 51     | 51  | 51   | 51  | 51      | 51  |
| 52  | 52  | 52   | 52  | 52     | 52  | 52   | 52  | 52      | 52  |
| 53  | 53  | 53   | 53  | 53     | 53  | 53   | 53  | 53      | 53  |
| 54  | 54  | 54   | 54  | 54     | 54  | 54   | 54  | 54      | 54  |
| 55  | 55  | 55   | 55  | 55     | 55  | 55   | 55  | 55      | 55  |
| 56  | 56  | 56   | 56  | 56     | 56  | 56   | 56  | 56      | 56  |
| 57  | 57  | 57   | 57  | 57     | 57  | 57   | 57  | 57      | 57  |
| 58  | 58  | 58   | 58  | 58     | 58  | 58   | 58  | 58      | 58  |
| 59  | 59  | 59   | 59  | 59     | 59  | 59   | 59  | 59      | 59  |
| 60  | 60  | 60   | 60  | 60     | 60  | 60   | 60  | 60      | 60  |
| 61  | 61  | 61   | 61  | 61     | 61  | 61   | 61  | 61      | 61  |
| 62  | 62  | 62   | 62  | 62     | 62  | 62   | 62  | 62      | 62  |
| 63  | 63  | 63   | 63  | 63     | 63  | 63   | 63  | 63      | 63  |
| 64  | 64  | 64   | 64  | 64     | 64  | 64   | 64  | 64      | 64  |
| 65  | 65  | 65   | 65  | 65     | 65  | 65   | 65  | 65      | 65  |
| 66  | 66  | 66   | 66  | 66     | 66  | 66   | 66  | 66      | 66  |
| 67  | 67  | 67   | 67  | 67     | 67  | 67   | 67  | 67      | 67  |
| 68  | 68  | 68   | 68  | 68     | 68  | 68   | 68  | 68      | 68  |
| 69  | 69  | 69   | 69  | 69     | 69  | 69   | 69  | 69      | 69  |
| 70  | 70  | 70   | 70  | 70     | 70  | 70   | 70  | 70      | 70  |
| 71  | 71  | 71   | 71  | 71     | 71  | 71   | 71  | 71      | 71  |
| 72  | 72  | 72   | 72  | 72     | 72  | 72   | 72  | 72      | 72  |
| 73  | 73  | 73   | 73  | 73     | 73  | 73   | 73  | 73      | 73  |
| 74  | 74  | 74   | 74  | 74     | 74  | 74   | 74  | 74      | 74  |
| 75  | 75  | 75   | 75  | 75     | 75  | 75   | 75  | 75      | 75  |
| 76  | 76  | 76   | 76  | 76     | 76  | 76   | 76  | 76      | 76  |
| 77  | 77  | 77   | 77  | 77     | 77  | 77   | 77  | 77      | 77  |
| 78  | 78  | 78   | 78  | 78     | 78  | 78   | 78  | 78      | 78  |
| 79  | 79  | 79   | 79  | 79     | 79  | 79   | 79  | 79      | 79  |
| 80  | 80  | 80   | 80  | 80     | 80  | 80   | 80  | 80      | 80  |
| 81  | 81  | 81   | 81  | 81     | 81  | 81   | 81  | 81      | 81  |
| 82  | 82  | 82   | 82  | 82     | 82  | 82   | 82  | 82      | 82  |
| 83  | 83  | 83   | 83  | 83     | 83  | 83   | 83  | 83      | 83  |
| 84  | 84  | 84   | 84  | 84     | 84  | 84   | 84  | 84      | 84  |
| 85  | 85  | 85   | 85  | 85     | 85  | 85   | 85  | 85      | 85  |
| 86  | 86  | 86   | 86  | 86     | 86  | 86   | 86  | 86      | 86  |
| 87  | 87  | 87   | 87  | 87     | 87  | 87   | 87  | 87      | 87  |
| 88  | 88  | 88   | 88  | 88     | 88  | 88   | 88  | 88      | 88  |
| 89  | 89  | 89   | 89  | 89     | 89  | 89   | 89  | 89      | 89  |
| 90  | 90  | 90   | 90  | 90     | 90  | 90   | 90  | 90      | 90  |
| 91  | 91  | 91   | 91  | 91     | 91  | 91   | 91  | 91      | 91  |
| 92  | 92  | 92   | 92  | 92     | 92  | 92   | 92  | 92      | 92  |
| 93  | 93  | 93   | 93  | 93     | 93  | 93   | 93  | 93      | 93  |
| 94  | 94  | 94   | 94  | 94     | 94  | 94   | 94  | 94      | 94  |
| 95  | 95  | 95   | 95  | 95     | 95  | 95   | 95  | 95      | 95  |
| 96  | 96  | 96   | 96  | 96     | 96  | 96   | 96  | 96      | 96  |
| 97  | 97  | 97   | 97  | 97     | 97  | 97   | 97  | 97      | 97  |
| 98  | 98  | 98   | 98  | 98     | 98  | 98   | 98  | 98      | 98  |
| 99  | 99  | 99   | 99  | 99     | 99  | 99   | 99  | 99      | 99  |
| 100 | 100 | 100  | 100 | 100    | 100 | 100  | 100 | 100     | 100 |

2

RECEIVED



00-06191

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                             |  |                                                                                                                              |                                                    |                                                                                                                                                             |  |                                                                        |  |                                                                                                                         |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR<br>Items 13a.-13E<br>5-15-86 A.L.<br>per phone                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                              |                                                    |                                                                                                                                                             |  |                                                                        |  |                                                                                                                         |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)<br>BABY BOY                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                              | 2a. DATE OF DEATH MONTH DAY YEAR<br>APRIL 24, 1986 |                                                                                                                                                             |  | 2b. HOUR<br>9 P.M.                                                     |  |                                                                                                                         |                                              |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>BLACK                                                                                                             |                                                    | 5. DATE OF BIRTH MONTH DAY YEAR<br>April 24, 1986                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>0 YRS.                              |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>- -                                                                                   |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US                                                                                           |                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.             |  |                                                                                                                         |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |                                                    |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>-     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-                                                                                  |                                              |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY<br>BALTO                                                                                                         |                                                    | 13c. CITY OR TOWN<br>BALTO                                                                                                                                  |  | 13d. STREET ADDRESS / ZIP CODE<br>209 BRIDGEVIEW Rd, 21225             |  |                                                                                                                         |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                              | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST         |                                                                                                                                                             |  |                                                                        |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                                                                         |                                                    | 17. INFORMANT ADDRESS                                                                                                                                       |  |                                                                        |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>EXTREME IMMATUREITY 21 WEEKS PRIOR</u> |  |                                                                                                                              |                                                    |                                                                                                                                                             |  |                                                                        |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                                           |  |                                                                                                                              |                                                    |                                                                                                                                                             |  |                                                                        |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                             |                                                    |                                                                                                                                                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                      |                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                        |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                          |                                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                        |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 24, 1986</u> to <u>April 24, 1986</u> , that (I) (we) last saw the deceased alive on <u>April 24, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                |  |                                                                                                                              |                                                    |                                                                                                                                                             |  |                                                                        |  |                                                                                                                         |                                              |
| 22b. SIGNATURE<br>Wilma Dario Dayrit                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                              |                                                    | DEGREE<br>M.D.                                                                                                                                              |  |                                                                        |  | 22c. DATE SIGNED<br>4/24/86                                                                                             |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Wilma DARIO DAYRIT                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                              |                                                    | 22e. ADDRESS<br>ST AGNES HOSPITAL BALTIMORE MD.                                                                                                             |  |                                                                        |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br>5/10/86                                                                                                         |                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL                                                                                                         |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE, MD. 21229        |  |                                                                                                                         |                                              |
| 24. FUNERAL DIRECTOR NAME<br>HUBBARD F. HOME 4107 WILKENS AVE. BALTO, MD. 21206                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                              |                                                    |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE               |  |                                                                                                                         |                                              |

BP



00-05906

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 2 9 8  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                            |  |                                                                                                                                |                                                                         |                                                                                                                                                             |  |                                                                                       |  |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Cecilia Williams                                                                                                                                                                                    |  |                                                                                                                                | 2a. DATE OF DEATH<br>5/6/86                                             |                                                                                                                                                             |  | 2b. HOUR<br>M                                                                         |  |                                              |  |
| 3. SEX<br>F                                                                                                                                                                                                                                |  | 4. RACE<br>Black                                                                                                               |                                                                         | 5. DATE OF BIRTH<br>MONDAY 4 15 10                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76                                                 |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>South Carolina                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                            |                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BAPTIST CITY OR COUNTY OF DEATH<br>Bartons MD.                                     |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Bartons                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |                                                                         |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Elevator Operator |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STREET<br>13b. CITY<br>13c. COUNTY<br>13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                                                | 13e. STREET ADDRESS / ZIP CODE<br>4901 Goodnow Road 21206               |                                                                                                                                                             |  |                                                                                       |  |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Willie Gibson                                                                                                                                                                                    |  |                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Cecilia Williams       |                                                                                                                                                             |  |                                                                                       |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Unknown                                                                                                                                                            |  |                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-32-7300A |                                                                                                                                                             |  | 17. INFORMANT<br>ADDRESS<br>Willie Beverly 4901 Goodnow Road                          |  |                                              |  |

|                                                                                                                                                                                                                      |  |                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a):<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b):<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c): |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| Cardiovascular Arrest                                                                                                                                                                                                |  |                                                 |  |
| Sepsis                                                                                                                                                                                                               |  |                                                 |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b):

|                                                                                                                                                                                                                                                                               |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OR CAUSE<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)                                                            |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WIKER <input type="checkbox"/> NOT WIKER <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>view the deceased alive on 5/6/86 to 5/6/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (b) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                               |  |
| 22b. SIGNATURE<br>MARIONAIS MD                                                                                                                                                                                                                                                |  | DEGREE                                                                 |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>5-7-86                                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                         |  | 22e. ADDRESS<br>901 BARTON PIKE CLAND                                  |  |                                                                                                                                            |  |                                                                                                                               |  |

|                                                                                    |  |                      |  |                                                           |  |                                                                   |  |
|------------------------------------------------------------------------------------|--|----------------------|--|-----------------------------------------------------------|--|-------------------------------------------------------------------|--|
| 23a. BURIAL CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                              |  | 23b. DATE<br>5/12/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Zion Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Lansdowne 20013 Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>March Funeral Homes 1101 East North Avenue |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 7 1986               |  | 25b. REGISTRAR'S SIGNATURE<br>John S. Swindler                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

THE UNIVERSITY OF CHICAGO  
LIBRARY

8000-0

20% cotton shirt

100/100

5/11/11



00-07728

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                   |  |                                                                                                                                                             |                                                                                                 |                                                                                      |  |                                                                                                                            |  | 8614299<br>REG. NO.                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ELIJAH WILLIAMS                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                   |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 25, 1986                                             |                                                                                      |  | 2b. HOUR<br>9:30 P.M.                                                                                                      |  |                                              |  |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>B                                                                                                                      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 7 25                                                                                                                |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |                                                                                                                            |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOME HOSPITAL |  |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |                                              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                              |  |                                                                                                                                   |  |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                      |  |                                                                                                                            |  |                                              |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                                                                       |  | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                              |                                                                                                 | 13e. STREET ADDRESS / ZIP CODE<br>2003 E. FEDERAL ST. 21213                          |  |                                                                                                                            |  |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>DAVID WILLIAM SR.                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ETHEL JOHNSON                                                                                              |                                                                                                 |                                                                                      |  |                                                                                                                            |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                                               |  |                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>225362099                                                                                                                       |                                                                                                 | 17. INFORMANT<br>ADDRESS<br>SHERMAN WILLIAMS 2727 W. GARRISON AVENUE                 |  |                                                                                                                            |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). CARCINOMA PANCREAS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                  |  |                                                                                                                                   |  |                                                                                                                                                             |                                                                                                 |                                                                                      |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: GASTROJEJUNOSTOMY WITH <del>EXTENSIVE</del> FISTULA, RENAL FAILURE                                                                                                                                                                                  |  |                                                                                                                                   |  |                                                                                                                                                             |                                                                                                 |                                                                                      |  |                                                                                                                            |  |                                              |  |
| 19a. DATE OF OPERATION<br>MAY 8, 1986                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>PANCREATIC CANCER                                                             |  |                                                                                                                                                             |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |                                                                                                 |                                                                                      |  |                                                                                                                            |  |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            |  | 21f. LOCATION<br>STREET                                                                                                                                     |                                                                                                 | CITY OR TOWN                                                                         |  | COUNTY                                                                                                                     |  | STATE                                        |  |
| 22a. I certify that (1) (his hospital) attended the deceased from MAY 2, 1986, to MAY 25, 1986, that (1) <input checked="" type="checkbox"/> lost saw the deceased alive on MAY 25, 1986, and that in (my <input checked="" type="checkbox"/> our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |                                                                                                                                   |  |                                                                                                                                                             |                                                                                                 |                                                                                      |  |                                                                                                                            |  |                                              |  |
| 22b. SIGNATURE<br><i>Paul Gormley</i>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |                                                                                                 |                                                                                      |  | 22c. DATE SIGNED<br>5/25/86                                                                                                |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL GORMLEY MD                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  | 22e. ADDRESS                                                                                                                                                |                                                                                                 |                                                                                      |  |                                                                                                                            |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br>5-30-86                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARBUTUS                                                                                                               |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN<br>ARBUTUS                                             |  | COUNTY                                                                                                                     |  | STATE<br>MARYLAND                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WM.C.MARCH FUNERAL HOME INC.                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                   |  | ADDRESS<br>1101 E. NORTH AVE.                                                                                                                               |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>MAY 27 1986                                         |  | 25b. REGISTRAR'S SIGNATURE                                                                                                 |  |                                              |  |

BP

DHMH - 16 60M 7/84  
(VIA 15, 4)

WILLIAMS



0-07875

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1, 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, if any, which may have contributed to the death.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                |  |                                                                                                                                                                |                                                                                      |                                                                   |                                                                                                                            |                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                |  |                                                                                                                                                                |                                                                                      |                                                                   |                                                                                                                            |                                                                 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Esters Jerry Williams</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                |  |                                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 21 86</b>                                |                                                                   | 2b. HOUR<br><b>M</b>                                                                                                       |                                                                 |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>Black</b>                                                                                                                        |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 1 1924</b>                                                                                                         |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.                 |                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD. |                                                                                                                            |                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1008 N. Woodyear St. 21217</b> |  |                                                                                                                                                                |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |                                                                                      | 13c. STREET ADDRESS / ZIP CODE<br><b>1008 Woodyear St. 21217</b>  |                                                                                                                            |                                                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Williams</b>                                                                                                                                                                                                                                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rebecca Briggs</b>                                                                         |  |                                                                                                                                                                |                                                                                      |                                                                   |                                                                                                                            |                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1950-1952</b>                                                                    |  | 17. INFORMANT<br>ADDRESS<br><b>Virginia Williams 1008 Woodyear St. 21217</b>                                                                                   |                                                                                      |                                                                   |                                                                                                                            |                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic adenocarcinoma of lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b> |  |                                                                                                                                                |  |                                                                                                                                                                |                                                                                      |                                                                   |                                                                                                                            |                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                |  |                                                                                                                                                                |                                                                                      |                                                                   |                                                                                                                            |                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |  |                                                                                                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                 |                                                                                      |                                                                   |                                                                                                                            |                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                                      |                                                                   |                                                                                                                            |                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 30</b> , 19 <b>86</b> , to <b>May 21</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>4-30</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                               |  |                                                                                                                                                |  |                                                                                                                                                                |                                                                                      |                                                                   |                                                                                                                            |                                                                 |  |
| 22b. SIGNATURE<br><b>Barbara A. Conley</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                      |                                                                   |                                                                                                                            | 22c. DATE SIGNED<br><b>5/22/86</b>                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARBARA A. CONLEY MD</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                |  | 22e. ADDRESS<br><b>VAMC Loch Raven Blvd. Baltimore Md</b>                                                                                                      |                                                                                      |                                                                   |                                                                                                                            |                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>5-28-86</b>                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Cemetery Owings Mills,</b>                                                                            |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MD</b>           |                                                                                                                            |                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Bailey Funeral Home 1348 N. Calhoun Street.</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 28 1986</b>                                                                                                            |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Jane Davidson-Hendricks</b>      |                                                                                                                            |                                                                 |  |



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

00-07891

|                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                     |  |                                                                                                                                                  |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                                           |          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------|----------|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                     |  |                                                                                                                                                  |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                                           | 8614301  |  |
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                     |  |                                                                                                                                                  |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                                           | REG. NO. |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JASPER WILLIAMS                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                     |  |                                                                                                                                                  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 15 86                                                                                                |                                                                                                 |                                                                                                                            | 2b. HOUR<br>7.15 P.M.                                        |                                           |          |  |
| 3 SEX<br>1 MALE                                                                                                                                                                                                                                                                                                                                                                                              |  | 4 RACE<br>BLACK                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10-22-1916                                                                                                    |                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS                                                       |                                                                                                                            | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.    |                                           |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.                                                |                                                                                                                            |                                                              |                                           |          |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PROVIDENT |  |                                                                                                                                                  |                                                                                                                                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                        |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                            |                                           |          |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br>BALTIMORE                                                                                            |  | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                   |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br>727 DRUID PARK DRIVE 21211 |                                           |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>EDWARD WILLIAMS                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                     |  |                                                                                                                                                  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SARAH HOBBS                                                                                  |                                                                                                 |                                                                                                                            |                                                              |                                           |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>224-05-9836A                                                                            |  | 17. INFORMANT ADDRESS<br>VIETTA THOMPSON 4617 REISTERSTOWN ROAD                                                                                  |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                                           |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE CONGESTIVE CARDIOMYOPATHY<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                     |  |                                                                                                                                                  |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                                           |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                           |  |                                                                                                                     |  |                                                                                                                                                  |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                                           |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                    |  |                                                                                                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                              |                                           |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)                                                                    |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                                           |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                                           |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 15th May 1986, to 15th May 1986, that (I) (we) last saw the deceased alive on 15th May 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                     |  |                                                                                                                     |  |                                                                                                                                                  |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                                           |          |  |
| 22b. SIGNATURE<br>Anthony C. Dike M.D. DEGREE                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                     |  |                                                                                                                                                  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 |                                                                                                                            | 22c. DATE SIGNED<br>5/15/86                                  |                                           |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ANTHONY C. DIKE, M.D.                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                     |  |                                                                                                                                                  | 22e. ADDRESS<br>PROVIDENT HOSPITAL, INC. BALTIMORE, MD                                                                                     |                                                                                                 |                                                                                                                            |                                                              |                                           |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>5-22-86                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. AUBURN Cem.                                                                                            |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE, MARYLAND                               |                                                                                                                            |                                                              |                                           |          |  |
| 24. FUNERAL DIRECTOR NAME<br>BROWN/THOMPSON F.H.                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                     |  |                                                                                                                                                  | 24b. ADDRESS<br>1913 W. BALTIMORE STREET                                                                                                   |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>MAY 28 1986                                                                               |                                                              | 25b. REGISTRAR'S SIGNATURE<br>[Signature] |          |  |

MEDICAL CERTIFICATION

99

10510-07



10510-07

00-07945

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 3 0 2

REG. NO.

|                                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                         |                                                                     |                                |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                          |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                       |                                                                     | 2b. HOUR                       |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                       |                                                                     | 2b. HOUR                       |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                               |                                                                                                        | MONTH DAY YEAR                                                                                                                                          |                                                                     | DAY YEAR                       |                                              |
| Jeannette M Williams                                                                                                                                                                                                                                                                                            |                                                                                                        | 5-26-86                                                                                                                                                 |                                                                     | 0310 A M                       |                                              |
| 3 SEX                                                                                                                                                                                                                                                                                                           | 4 RACE                                                                                                 | 5. DATE OF BIRTH                                                                                                                                        | 6 AGE (IN YEARS LAST BIRTHDAY)                                      | IF UNDER 1 YEAR                |                                              |
| Female                                                                                                                                                                                                                                                                                                          | Black                                                                                                  | MONTH DAY YEAR                                                                                                                                          | 66 YRS                                                              | IF UNDER 24 HRS                |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |                                |                                              |
| MD                                                                                                                                                                                                                                                                                                              | USA                                                                                                    |                                                                                                                                                         | Baltimore City MD                                                   |                                |                                              |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                           | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                       | St. Agnes Hospital                                                                                     | 4465 MAXER                                                                                                                                              | AT HOME                                                             |                                |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                      | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                       | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS / ZIP CODE |                                              |
| MD                                                                                                                                                                                                                                                                                                              | BALTO                                                                                                  | ARONSVILLE                                                                                                                                              | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 174 Winters Lane #21228        |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                               | 15. MOTHER'S MAIDEN NAME                                                                               | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                       |                                                                     |                                |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                               | FIRST MIDDLE LAST                                                                                      | 16b. SOCIAL SECURITY NO                                                                                                                                 |                                                                     |                                |                                              |
| Sammy Coe                                                                                                                                                                                                                                                                                                       | Estelle                                                                                                | 214-12-4788                                                                                                                                             |                                                                     |                                |                                              |
| 17 INFORMANT                                                                                                                                                                                                                                                                                                    |                                                                                                        | ADDRESS                                                                                                                                                 |                                                                     |                                |                                              |
|                                                                                                                                                                                                                                                                                                                 |                                                                                                        | 900 S. Caton Ave. # 21229                                                                                                                               |                                                                     |                                |                                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                         |                                                                     |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                         |                                                                     |                                |                                              |
| IMMEDIATE CAUSE (a) Ventricular Fibrillation                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                         |                                                                     |                                | 30 min                                       |
| DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                         |                                                                     |                                |                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                         |                                                                     |                                |                                              |
| (b) Auto Injury resulting in Myocardial Infarction                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                         |                                                                     |                                | 30 min                                       |
| DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                         |                                                                     |                                |                                              |
| (c) Hypertensive Interhemorrhagic Hemiparesis                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                         |                                                                     |                                | 32 yrs                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                         |                                                                     |                                |                                              |
| Diabetes Mellitus                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                         |                                                                     |                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       | 20a. AUTOPSY?                                                                                                                                           | 20b. IF WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?           |                                |                                              |
|                                                                                                                                                                                                                                                                                                                 |                                                                                                        | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                              | 21b. TIME OF INJURY                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                           |                                                                     |                                |                                              |
|                                                                                                                                                                                                                                                                                                                 | HOUR A.M. MONTH DAY YEAR                                                                               |                                                                                                                                                         |                                                                     |                                |                                              |
|                                                                                                                                                                                                                                                                                                                 | P.M. 19                                                                                                |                                                                                                                                                         |                                                                     |                                |                                              |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                            | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION                                                                                                                                           |                                                                     |                                |                                              |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                               |                                                                                                        | STREET CITY OR TOWN COUNTY STATE                                                                                                                        |                                                                     |                                |                                              |
|                                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                         |                                                                     |                                |                                              |
| 22a. I certify that (I) (the hospital) attended the deceased from 10:31, 1985, to 11-6, 1985, that (I) (we) last saw the deceased alive on 11-5, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                         |                                                                     |                                |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                  |                                                                                                        | DEGREE                                                                                                                                                  |                                                                     | 22c. DATE SIGNED               |                                              |
| Rylee G. Swisher Jr MD                                                                                                                                                                                                                                                                                          |                                                                                                        | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>                       |                                                                     | 5-26-86                        |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                           |                                                                                                        | 22e. ADDRESS                                                                                                                                            |                                                                     |                                |                                              |
| Rylee G. Swisher Jr                                                                                                                                                                                                                                                                                             |                                                                                                        | 3455 Wilkes Ave. Balt 21229                                                                                                                             |                                                                     |                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL                                                                                                                                                                                                                                                                                 | 23b. DATE                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                      | 23d. LOCATION                                                       |                                |                                              |
| Burial                                                                                                                                                                                                                                                                                                          | 5/29/86                                                                                                | MD Veterans                                                                                                                                             | Reveries Mills MD                                                   |                                |                                              |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                            |                                                                                                        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                           |                                                                     | 25b. REGISTRAR'S SIGNATURE     |                                              |
| NAME ADDRESS                                                                                                                                                                                                                                                                                                    |                                                                                                        | MAY 28 1986                                                                                                                                             |                                                                     | Guiden Randall                 |                                              |
| Michael P. Hays 638 N. 9th St                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                         |                                                                     |                                |                                              |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                       |  | 2a. DATE OF DEATH                                                                                      |  | MONTH DAY YEAR                                                                                                                                              |  | 2b. HOUR                                                       |  | M                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                             |  | FIRST MIDDLE LAST                                                                                      |  | Lewis E. Williams                                                                                                                                           |  | 5 21 86                                                        |  |                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                       |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | 7. IF UNDER 1 YEAR                           |  |
| Male                                                                                                                                                                                                                                                                                                         |  | Black                                                                                                  |  | MONTH DAY YEAR<br>10 2 31                                                                                                                                   |  | 54 YRS                                                         |  | MONTHS DAYS HOURS MIN                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |                                              |  |
| Va.                                                                                                                                                                                                                                                                                                          |  | USA                                                                                                    |  |                                                                                                                                                             |  | Baltimore City                                                 |  | MD.                                          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |                                              |  |
| Balto.                                                                                                                                                                                                                                                                                                       |  | 4147 Fairview Avenue 2nd Fl.                                                                           |  | Retired                                                                                                                                                     |  | Gov't                                                          |  |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. STREET ADDRESS / ZIP CODE                                 |  | 21216                                        |  |
| Md.                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  | Balto.                                                                                                                                                      |  | 4147 Fairview Ave. 2nd Floor                                   |  |                                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                           |  | 16b. SOCIAL SECURITY NO.                                       |  | 17. INFORMANT ADDRESS                        |  |
| Yarborough B. Williams, Sr.                                                                                                                                                                                                                                                                                  |  | Mattie B. Alston                                                                                       |  | No                                                                                                                                                          |  | 227-34-2943                                                    |  | Myrtle R. Williams 4147 Fairview Ave.        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                        |  | IMMEDIATE CAUSE (a)                                                                                    |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                              |  | DUE TO, OR AS A CONSEQUENCE OF                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|                                                                                                                                                                                                                                                                                                              |  | Cardiomyopathy                                                                                         |  |                                                                                                                                                             |  |                                                                |  | 10 months                                    |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                |  |                                                                                                        |  | Diabetes mellitus, Type I                                                                                                                                   |  |                                                                |  | 20 yrs                                       |  |
|                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                              |  |
|                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |  |                                                                |  |                                              |  |
|                                                                                                                                                                                                                                                                                                              |  | P.M. 19                                                                                                |  |                                                                                                                                                             |  |                                                                |  |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET                                                                                                                                        |  | CITY OR TOWN                                                   |  | COUNTY STATE                                 |  |
|                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 19 64, to Apr 22 19 86, that (I) (we) last saw the deceased alive on Apr 22 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                |  |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                               |  | DEGREE                                                                                                 |  | 22c. DATE SIGNED                                                                                                                                            |  |                                                                |  |                                              |  |
| Stuart H Brager MD                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | 5/22/86                                                                                                                                                     |  |                                                                |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                        |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                             |  |                                                                |  |                                              |  |
| Stuart Brager MD                                                                                                                                                                                                                                                                                             |  | 2360 W. Joppa Rd. Lutherville                                                                          |  |                                                                                                                                                             |  |                                                                |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                    |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION CITY OR TOWN                                     |  | COUNTY STATE                                 |  |
| Burial                                                                                                                                                                                                                                                                                                       |  | 5/24/86                                                                                                |  | Cedar Hill Cem.                                                                                                                                             |  | Anne Arundel Co., Md.                                          |  |                                              |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                    |  | ADDRESS                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE                                     |  |                                              |  |
| Wm C March F/H West                                                                                                                                                                                                                                                                                          |  | 4300 Wabash Avenue                                                                                     |  | MAY 23 1986                                                                                                                                                 |  | John Davidson                                                  |  |                                              |  |

BP

438844



00-07199

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove completed pages 1, 2, and 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked off, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP  
DHMH - 16 60M 7/84  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 1 4 3 0 4  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                            |                                                                                                                                                             |                                                                               |                                                                                      |                                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MINNIE G. WILLIAMS                                                                                                                                                                                                                                                                                                        |                                                                                                                                            |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 20 86                                |                                                                                      | 2b. HOUR<br>7 30 PM                                                                                                           |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br>White                                                                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>09 25 1890                                                                                                            |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>95                                                | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                            | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |                                                                                                                               |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL 21218 |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                           |                                                                                                                                            |                                                                                                                                                             | 13b. COUNTY<br>--                                                             | 13c. CITY OR TOWN<br>Baltimore                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick May                                                                                                                                                                                                                                                                                                          |                                                                                                                                            |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose Davidson                |                                                                                      |                                                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                       |                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-14-0697                                                                                      |                                                                               | 17. INFORMANT<br>ADDRESS<br>Leroy Williams 3713 Clipper Road 21211                   |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>septic shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Fever of unknown origin</u>                                                                  |                                                                                                                                            |                                                                                                                                                             |                                                                               |                                                                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>minutes</u><br><u>24 hour</u>                                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                 |                                                                                                                                            |                                                                                                                                                             |                                                                               |                                                                                      |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                         |                                                                                                                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                        |                                                                                                                                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> , 19 <u>86</u> to <u>May 20</u> , 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>5/20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                            |                                                                                                                                                             |                                                                               |                                                                                      |                                                                                                                               |
| 22b. SIGNATURE<br><u>menkado</u>                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                            | DEGREE                                                                                                                                                      |                                                                               | 22c. DATE SIGNED<br><u>5-20-86</u>                                                   |                                                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARIE CHRISTINE NKODO                                                                                                                                                                                                                                                                                                   |                                                                                                                                            | 22e. ADDRESS<br>@ 201 W. UNIVERSITY PARKWAY                                                                                                                 |                                                                               |                                                                                      |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                           |                                                                                                                                            | 23b. DATE<br>5/23/86                                                                                                                                        |                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Mary's Cemetery                            |                                                                                                                               |
| 23d. LOCATION<br>CITY OR TOWN<br>Hampden                                                                                                                                                                                                                                                                                                                         |                                                                                                                                            | COUNTY<br>Hampden                                                                                                                                           |                                                                               | STATE<br>Maryland                                                                    |                                                                                                                               |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz, Jr.                                                                                                                                                                                                                                                                                                               |                                                                                                                                            |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>MAY 21 1986                                  |                                                                                      |                                                                                                                               |
| ADDRESS<br>3615-19 Chestnut Ave. 21211                                                                                                                                                                                                                                                                                                                           |                                                                                                                                            |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>                    |                                                                                      |                                                                                                                               |

MEDICAL CERTIFICATION



00-07547

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

14305

|                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |                                                                               |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                      |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>N. Page Williams</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 24, 1986</b>                    |                                                                                                                                                             |                                                                                                                                                      | 2b. HOUR<br>M                                                                                   |                                                                      |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>White</b>                                                                                                            |                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 22, 1901</b>                                                                                                  |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b>                                                    |                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         |                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>city</b>                                             |                                                                      |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(AND IN SUCH CASE, GIVE STREET ADDRESS)<br><b>Edgewood Nursing Home</b> |                                                                               |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Book Keeper Balto.</b>   |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>City Ret.</b>                                                                      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |                                                                               |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                      |                                                                                                                            |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY                                                                                                                        |                                                                               | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                      | 13e. STREET ADDRESS / ZIP CODE<br><b>3309 Glenmore Avenue 21214</b>                                                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Edward Forsythe</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |                                                                               |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amanda Elizabeth Snyder</b>                                                                      |                                                                                                 |                                                                      |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                              |  |                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-03-7838</b> |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Maude Bentley Same</b>                                                                                           |                                                                                                 |                                                                      |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASEVD.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |                                                                                                                                    |                                                                               |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>4 days</b>                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Senile dementia</b>                                                                                                                                                                                                        |  |                                                                                                                                    |                                                                               |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                      |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |                                                                                                                                                             |                                                                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |  |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                                                 |                                                                      |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                |  |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                                 |                                                                      |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan-30</b> 19 <b>85</b> to <b>May 24</b> 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>May 24</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                    |                                                                               |                                                                                                                                                             |                                                                                                                                                      |                                                                                                 |                                                                      |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>B. Matos MD</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    |                                                                               |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 |                                                                      | 22c. DATE SIGNED<br><b>5/26/86</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bienvenido Matos MD</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |                                                                               |                                                                                                                                                             | 22e. ADDRESS<br><b>Yorktown Plaza Cockeysville Maryland</b>                                                                                          |                                                                                                 |                                                                      |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    | 23b. DATE<br><b>May 27, 1986</b>                                              |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mountain View</b>                                                                                           |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Howard Maryland</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |                                                                               |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 26 1986</b>                                                                                                  |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson</b>                     |                                                                                                                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-08344

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 14306  
REG. NO.

|                                                                                   |                                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                               |                                   |
|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROSETTA S. WILLIAMS</b>                 |                                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 29, 1986</b>                                                                                                  |                                                                                                 | 2b. HOUR<br><b>11:55pM</b>                                                    |                                   |
| 3. SEX<br><b>FEMALE</b>                                                           | 4. RACE<br><b>BLACK</b>                                                                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5/2/1919</b>                                                                                                       |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b><br>YRS MONTHS DAYS HOURS MIN.    |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>MD</b>                                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.             |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MARYLAND GENERAL HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>              |                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>MD</b>                                                           | 13b. COUNTY<br><b>AA</b>                                                                                                                      | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>105 N. HOLLINS FERRY RD 21067</b>        |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>RICHARD SCOTT</b>                    |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CORA HAMMOND</b>                                                                                        |                                                                                                 |                                                                               |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br><b>577-24-5923</b>                                                                                                              |                                                                                                 | 17. INFORMANT<br>ADDRESS<br><b>DONALD GAITHER 2301 CALVERTON HIGHT AVENUE</b> |                                   |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **AMYOTROPHIC LATERAL SCLEROSIS**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**1 1/2 years**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) \_\_\_\_\_

DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                 |                                                                                                                                                                     |                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION<br><b>May 22, 1986</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Inability to Swallow</b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                      |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                   |                                                                                                                               |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 20,</b> 19 <b>86</b> , to <b>May 29,</b> 19 <b>86</b> that <input checked="" type="checkbox"/> (we) last<br>saw the deceased alive on <b>MAY 29,</b> 19 <b>86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |                                                                                 |                                                                                                                                                                     |                                                                                                                               |
| 22b. SIGNATURE<br><b>Timothy J. Low</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                 | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>5/30/86</b>                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TIMOTHY J. LOW</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                 | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                                                |                                                                                                                               |

|                                                                                               |                             |                                                                  |                                                                   |
|-----------------------------------------------------------------------------------------------|-----------------------------|------------------------------------------------------------------|-------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>                              | 23b. DATE<br><b>5/31/86</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREENMOUNT CEMETERY</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WM. C. MARCH FUNERAL HOME West 4300 Wabash Ave</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 3 1986</b>               | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 states only injury, or other traumatic event, the medical examiner shall be notified at once.

1961 NOTED 10/2

1961 NOTED 10/2

8

00-08103

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14307

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |                                                                            |                                                                                                                                                             |                                                                                      |                                                                                     |                                                                                                                            |                                                                    |                                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>William G. Williams Sr.</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 31, 1986</b>                 |                                                                                                                                                             |                                                                                      | 2b. HOUR<br>P M<br><b>12:40</b>                                                     |                                                                                                                            |                                                                    |                                                                    |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>White</b>                                                                                                                     |                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 8, 1907</b>                                                                                                   |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                   |                                                                                                                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |                                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |                                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |                                                                                                                            |                                                                    |                                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |                                                                            |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b> |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                  |                                                                    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                      |  |                                                                                                                                             | 13b. COUNTY                                                                |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                |                                                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                                    | 13e. STREET ADDRESS / ZIP CODE<br><b>3043 Fleetwood Ave. 21214</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William H. Williams</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth E. Houck</b> |                                                                                                                                                             |                                                                                      |                                                                                     |                                                                                                                            |                                                                    |                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-9341</b>                                                                                              |                                                                            | 17. INFORMANT ADDRESS<br><b>Thelma E. Williams 3043 Fleetwood Ave. 21214</b>                                                                                |                                                                                      |                                                                                     |                                                                                                                            |                                                                    |                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                                                                             |                                                                            |                                                                                                                                                             |                                                                                      |                                                                                     |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>11 mos</b>      |                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                |  |                                                                                                                                             |                                                                            |                                                                                                                                                             |                                                                                      |                                                                                     |                                                                                                                            |                                                                    |                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |                                                                            |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                    |                                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                  |                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                      |                                                                                     |                                                                                                                            |                                                                    |                                                                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                     |                                                                                                                            |                                                                    |                                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 25, 1965</b> to <b>May 31, 1986</b> , that (I) (we) last saw the deceased alive on <b>Dec 31, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.                                        |  |                                                                                                                                             |                                                                            |                                                                                                                                                             |                                                                                      |                                                                                     |                                                                                                                            |                                                                    |                                                                    |  |
| 22b. SIGNATURE<br><b>Ronald Jandorf</b> M.D.                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             |                                                                            | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                      |                                                                                     |                                                                                                                            | 22c. DATE SIGNED<br><b>6-2-86</b>                                  |                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. R. Donald Jandorf M.D.</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             |                                                                            | 22e. ADDRESS<br><b>7403 Harford Road Baltimore, Md.</b>                                                                                                     |                                                                                      |                                                                                     |                                                                                                                            |                                                                    |                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>Jun 3 1986</b>                                                                                                              |                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial</b>                                                                                              |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>             |                                                                                                                            |                                                                    |                                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                             |                                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 2 1986</b>                                                                                                          |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                    |                                                                                                                            |                                                                    |                                                                    |  |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



12:00  
May 31, 1950  
William G. ...

John ...  
U.S.A.  
X  
Baltimore City

John ...  
Baltimore  
3045 Woodwood Ave. 21214

William H. ...  
Baltimore

215-25-2541  
William H. ...  
3045 Woodwood Ave. 21214



William H. ...  
Baltimore  
3045 Woodwood Ave. 21214  
William H. ...  
Baltimore  
3045 Woodwood Ave. 21214

0-07810

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

14308

|                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                                       |                         |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------|-------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                              |                                                                                                           | FIRST                                                                                                                                                       | MIDDLE                                                                | LAST                    | 2a DATE OF DEATH                                                                               | MONTH                                                                                                                                      | DAY                                        | YEAR                                                           | 2b HOUR                                         |
| PHILLIP                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | WILLIAMSON                                                                                                                                                  |                                                                       |                         | 5                                                                                              | 19                                                                                                                                         | 86                                         |                                                                | 3:45 P.M.                                       |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                           | 4 RACE                                                                                                    | 5. DATE OF BIRTH                                                                                                                                            |                                                                       |                         | 6 AGE (IN YEARS LAST BIRTHDAY)                                                                 |                                                                                                                                            | IF UNDER 1 YEAR                            |                                                                | IF UNDER 24 HRS                                 |
| M                                                                                                                                                                                                                                                                                                                                                               | B                                                                                                         | 8 5 25                                                                                                                                                      |                                                                       |                         | 60                                                                                             |                                                                                                                                            | YRS                                        |                                                                | MONTHS DAYS HOURS MIN.                          |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                     | 7b CITIZEN OF WHAT COUNTRY?                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                       |                         | 9 BALTIMORE CITY OR COUNTY OF DEATH                                                            |                                                                                                                                            |                                            |                                                                |                                                 |
| VA.                                                                                                                                                                                                                                                                                                                                                             | U.S.A.                                                                                                    |                                                                                                                                                             |                                                                       |                         | BALTIMORE MD.                                                                                  |                                                                                                                                            |                                            |                                                                |                                                 |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             |                                                                       |                         | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                                                                                                                            | 12b KIND OF BUSINESS OR INDUSTRY           |                                                                |                                                 |
| BALTIMORE CITY                                                                                                                                                                                                                                                                                                                                                  | UNION MEMORIAL HOSPITAL                                                                                   |                                                                                                                                                             |                                                                       |                         | DELIVERY                                                                                       |                                                                                                                                            |                                            |                                                                |                                                 |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                       |                         | 13a STREET ADDRESS / ZIP CODE                                                                  |                                                                                                                                            |                                            |                                                                |                                                 |
| 13a STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                           |                                                                                                           | 13b COUNTY                                                                                                                                                  |                                                                       | 13c CITY OR TOWN        | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                            |                                            |                                                                |                                                 |
|                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                                       | BALTIMORE               | 813 CATOR AVE. 21218                                                                           |                                                                                                                                            |                                            |                                                                |                                                 |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             |                                                                       | 15 MOTHER'S MAIDEN NAME |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |                                                                       | FIRST MIDDLE LAST       |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
| WILLIAM                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                       | ELLA                    |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
|                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                                       | AUSTIN                  |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             |                                                                       | 16b SOCIAL SECURITY NO. |                                                                                                | 17 INFORMANT ADDRESS                                                                                                                       |                                            |                                                                |                                                 |
| YES                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             |                                                                       | 228226918               |                                                                                                | DORETHA JACKSON 813 CATOR AVE. 21218                                                                                                       |                                            |                                                                |                                                 |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |                                                                       |                         |                                                                                                |                                                                                                                                            |                                            |                                                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             |                                                                       |                         |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
| IMMEDIATE CAUSE (a) <u>REPAIRING ROOF</u>                                                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |                                                                       |                         |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                       |                         |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                       |                         |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                       |                         |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
| (c) <u>METASTATIC LUNG CANCER.</u>                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             |                                                                       |                         |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             |                                                                       |                         |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
| <u>COPD</u>                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             |                                                                       |                         |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |                                                                                                           |                                                                                                                                                             | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                         |                                                                                                | 20a AUTOPSY?                                                                                                                               |                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                                 |
|                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                                       |                         |                                                                                                | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                 |                                                                                                                                            |                                            |                                                                |                                                 |
|                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                                       |                         |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
| 21d INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                         | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                                            |                                            |                                                                |                                                 |
| WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |                                                                       |                         |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
| 22a I certify that (I) (this hospital) attended the deceased from <u>5/7</u> 19 <u>86</u> , to <u>5/19</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/19</u> 19 <u>86</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                           |                                                                                                                                                             |                                                                       |                         |                                                                                                |                                                                                                                                            |                                            |                                                                |                                                 |
| 22b SIGNATURE                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             | DEGREE                                                                |                         |                                                                                                | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                            | 22c. DATE SIGNED                                               |                                                 |
| <u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             |                                                                       |                         |                                                                                                |                                                                                                                                            |                                            | <u>5/19/86</u>                                                 |                                                 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             |                                                                       |                         | 22e ADDRESS                                                                                    |                                                                                                                                            |                                            |                                                                |                                                 |
| Dr. L. I. Kitchen                                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |                                                                       |                         | UNION MEMORIAL HOSPITAL                                                                        |                                                                                                                                            |                                            |                                                                |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             | 23b. DATE                                                             |                         | 23c. NAME OF CEMETERY OR CREMATORY                                                             |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |                                                                |                                                 |
| BURIAL                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             | 5-28-86                                                               |                         | GARRISON FOREST                                                                                |                                                                                                                                            | OWING MILLS MARYLAND                       |                                                                |                                                 |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             |                                                                       |                         | 25a. DATE REC'D. BY REGISTRAR                                                                  |                                                                                                                                            | 25b. REGISTRAR'S SIGNATURE                 |                                                                |                                                 |
| WM.C.MARCH FUNERAL HOME INC. 1101 E.NORTH AVE.                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                       |                         | MAY 27 1986                                                                                    |                                                                                                                                            | <u>[Signature]</u>                         |                                                                |                                                 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7/12



4  
00-07889STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

143047

|                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        |                                                       |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Reaves Willie</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 22 86</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>1010</b> M                                                                       |  |                                                                                                                            |                                                |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>Black</b>                                                                                                                |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>XX 07-08-24</b>                                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b>                                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN.                                                         |                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Baltimore</b>                                                                                       |                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                |  |                                                                                                                            |                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>XXX St. Agnes Hosp</b> |                                                       |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Truck Driver</b>                                                                   |                                                |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                        |                                                       | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                                            |                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charlie Reaves</b>                                                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bloomie McQueen</b>                                                                |                                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                               |  |                                                                                                 |  |                                                                                                                            | 16b. SOCIAL SECURITY NO.<br><b>251-26-0240</b> |  |
| 17. INFORMANT<br>ADDRESS<br><b>Dorothy Reaves 3742 Old Frederick</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                       |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction immediate</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                        |                                                       |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>_____                                                                                                                                                                                                                                    |  |                                                                                                                                        |                                                       |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |                                                       |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                      |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |                                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 19 76</b> to <b>May 19 86</b> , that (I) (we) last saw the deceased alive on <b>May 19 19 86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                         |  |                                                                                                                                        |                                                       |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                                |  |
| 22b. SIGNATURE<br><b>Barry J. Weckesser</b> DEGREE                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |                                                       |                                                                                                                                                             |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>5/27/86</b>                                                                                         |                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Barry J. Weckesser, M.D.</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        |                                                       | 22e. ADDRESS<br><b>301 St. Paul Place Baltimore, Md 21202</b>                                                                                               |  |                                                                                                 |  |                                                                                                                            |                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>05-27-86</b>                                                                                                           |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cemetery</b>                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |                                                                                                                            |                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Brown/Thompson F.H. 1913 W. Baltimore Street</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 28 1986</b>                                                                                                         |  |                                                                                                 |  |                                                                                                                            |                                                |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |                                                       |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

2005-0-0

1000

1000

1000

1000

1000

1000

1000



0-07103

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 14310  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                    |  |                                                                                                                                                                                            |                                                           |                                                                                                                                                             |                            |                                                                                     |  |
|------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>JOHN B. WILLING</u> |  |                                                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>MAY 7, 1986</u> |                                                                                                                                                             | 2b. HOUR<br><u>7:30</u> AM |                                                                                     |  |
| 3. SEX<br><u>Male</u>                                                              |  | 4. RACE<br><u>White</u>                                                                                                                                                                    |                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>10 19 1918</u>                                                                                                     |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>67</u> YRS.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Salisbury, Maryland</u>            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                              |                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Maryland General Hospital</u>                                              |                                                           |                                                                                                                                                             |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Salesman</u> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                  |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>Maryland</u> 13b. COUNTY <u>Baltimore</u> 13c. CITY OR TOWN <u>Baltimore</u> |                                                           |                                                                                                                                                             |                            |                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Clayton C. Willing</u>                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Mary Ann Morris</u>                                                                                                                    |                                                           | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                        |                            |                                                                                     |  |
| 16b. SOCIAL SECURITY NO.<br><u>219-07-6000</u>                                     |  | 17. INFORMANT <u>Mrs. Buela Twilley (Sister)</u><br>ADDRESS <u>Route #4 Airport Road, Salisbury, Md. 21801</u>                                                                             |                                                           |                                                                                                                                                             |                            |                                                                                     |  |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Metastatic small cell carcinoma to the liver</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>with abstractive jaundice.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Gastritis with gastrointestinal bleeding (300cc) blood</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>in gastrointestinal tract.</u><br>(c) <u>Pulmonary emboli, small, with pulmonary infarction</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                                       |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)                                                              |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                                       |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 30,</u> 19 <u>86</u> , to <u>May 7,</u> 19 <u>86</u> , that <input checked="" type="checkbox"/> we lost<br>saw the deceased alive on <u>May 7,</u> 19 <u>86</u> , and that in <input checked="" type="checkbox"/> our opinion death occurred on the date and hour and from the causes stated<br>above. <input checked="" type="checkbox"/> we did not see the body after death. |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | DEGREE                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>5/7/86</u>                                                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Jonathan D. Kushner</u>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 22e. ADDRESS<br><u>c/o Maryland General Hospital</u>                   |  |                                                                                                                                            |  |                                                                                                                                       |  |

|                                                                                                 |  |                              |  |                                                               |  |                                                                                   |  |
|-------------------------------------------------------------------------------------------------|--|------------------------------|--|---------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>                                   |  | 23b. DATE<br><u>5/9/1986</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Parsons Cemetery</u> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Salisbury Wicomico, Maryland</u> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Holloway Funeral Home, P.A., Salisbury, Maryland</u> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAY 20 1986</u>           |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requiring that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

0-01103





0-07961

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, WITHIN 72 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFERMENT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |         | FIRST                                                                                                   | MIDDLE                   | LAST                                                                                                                                                                | 2a. DATE OF DEATH       | 2b. HOUR                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------|
| LOUIS A. WILSON                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                         |                          |                                                                                                                                                                     | 5-17-86                 | 2:40a                                                               |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE | 5. DATE OF BIRTH                                                                                        | 6. AGE (IN YEARS)        | IF UNDER 1 YR.                                                                                                                                                      | IF UNDER 24 HRS.        | 7c. DATE PRONOUNCED DEAD                                            |
| M                                                                                                                                                                                                                                                                                                                                                                                                                                        | B       | 11 24 49                                                                                                | 36 YRS.                  | MONTHS                                                                                                                                                              | DAYS                    | 5-17-86                                                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                            |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                         | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                 |         | U.S.A.                                                                                                  |                          |                                                                                                                                                                     |                         | Baltimore City                                                      |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                       |                         | 12b. KIND OF BUSINESS OR INDUSTRY                                   |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                |         | 1625 Pentwood Street                                                                                    |                          | GIANT FOODS CO.                                                                                                                                                     |                         |                                                                     |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                               |         | 13b. COUNTY                                                                                             | 13c. CITY OR TOWN        | 13d. INSIDE CITY LIMITS?                                                                                                                                            | 13e. STREET ADDRESS     |                                                                     |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                                                         | BALTIMORE                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                 | 2718 FENWICK AVE. 21218 |                                                                     |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                                                         | 15. MOTHER'S MAIDEN NAME |                                                                                                                                                                     |                         |                                                                     |
| LOUIS P. WILSON                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                         | DOROTHY L. DABNEY        |                                                                                                                                                                     |                         |                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                       |         | 16b. SOCIAL SECURITY NO.                                                                                |                          | 17. INFORMANT ADDRESS                                                                                                                                               |                         |                                                                     |
| NO                                                                                                                                                                                                                                                                                                                                                                                                                                       |         | 219526840                                                                                               |                          | DOROTHY WILSON 2718 FENWICK AVE. 21218                                                                                                                              |                         |                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                |         |                                                                                                         |                          |                                                                                                                                                                     |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotism                                                                                                                                                                                                                                                                                                                                                                                |         |                                                                                                         |                          |                                                                                                                                                                     |                         |                                                                     |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                                                                                                                                                                                                                                                                                                                            |         |                                                                                                         |                          |                                                                                                                                                                     |                         |                                                                     |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                       |         |                                                                                                         |                          |                                                                                                                                                                     |                         |                                                                     |
| (c) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                       |         |                                                                                                         |                          |                                                                                                                                                                     |                         |                                                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                           |         |                                                                                                         |                          |                                                                                                                                                                     |                         |                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                       |                          |                                                                                                                                                                     |                         | 20. AUTOPSY?                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                         |                          |                                                                                                                                                                     |                         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |         | 21b. TIME OF INJURY                                                                                     |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                       |                         |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         | HOUR A.M. MONTH DAY YEAR                                                                                |                          |                                                                                                                                                                     |                         |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         | P.M. 19                                                                                                 |                          |                                                                                                                                                                     |                         |                                                                     |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                          |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                             |                          | 21f. LOCATION                                                                                                                                                       |                         |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                         |                          | STREET CITY OR TOWN COUNTY STATE                                                                                                                                    |                         |                                                                     |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . |         |                                                                                                         |                          |                                                                                                                                                                     |                         |                                                                     |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                         |         | TITLE (SPECIFY)                                                                                         |                          |                                                                                                                                                                     | DATE SIGNED             |                                                                     |
| Margarita A. Korell                                                                                                                                                                                                                                                                                                                                                                                                                      |         | M.D. Assistant                                                                                          |                          |                                                                                                                                                                     | 5-17-86                 |                                                                     |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                          |         | ADDRESS                                                                                                 |                          |                                                                                                                                                                     |                         |                                                                     |
| Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                |         | 111 Penn Street                                                                                         |                          |                                                                                                                                                                     |                         |                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                |         | 23b. DATE                                                                                               |                          | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                  |                         | 23d. LOCATION                                                       |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | 5-22-86                                                                                                 |                          | ARBUTUS                                                                                                                                                             |                         | ARBUTUS                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                         |                          |                                                                                                                                                                     |                         | COUNTY MARYLAND                                                     |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                                                                         |                          | 25a. DATE REC'D. BY REGISTRAR                                                                                                                                       |                         |                                                                     |
| WM.C.MARCH F/H INC. 1101 EAST NORTH AVENUE                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                         |                          | MAY 29 1986                                                                                                                                                         |                         |                                                                     |

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(VR A15 ME (5))



00-08351

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or coroner, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card, page 4, and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the funeral examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               |                                    |                 |                                                                     |                                                                               |                                |                                                                |          |            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------|-----------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------|----------|------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                        |  | 86                                                                                                     |  | 14312                                                                                                                                                    |                                                                     | REG. NO.                                                      |                                    |                 |                                                                     |                                                                               |                                |                                                                |          |            |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          | 2a. DATE OF DEATH                                                   |                                                               | MONTH                              |                 | DAY                                                                 |                                                                               | YEAR                           |                                                                | 2b. HOUR |            |  |
| Thomas A. Wilson, Jr.                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          | 5                                                                   |                                                               | 25                                 |                 | 86                                                                  |                                                                               |                                |                                                                | M        |            |  |
| 3. SEX                                                                                                                                                                                                                                                                                                        |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)                               |                                    | IF UNDER 1 YEAR |                                                                     | IF UNDER 24 HRS                                                               |                                |                                                                |          |            |  |
| Male                                                                                                                                                                                                                                                                                                          |  | Black                                                                                                  |  | 3 24 27                                                                                                                                                  |                                                                     | 59                                                            |                                    | YRS.            |                                                                     | MONTHS                                                                        |                                | DAYS                                                           |          | HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |                                    |                 |                                                                     |                                                                               |                                |                                                                |          |            |  |
| Md.                                                                                                                                                                                                                                                                                                           |  | USA                                                                                                    |  |                                                                                                                                                          |                                                                     | Baltimore City MD.                                            |                                    |                 |                                                                     |                                                                               |                                |                                                                |          |            |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |                                                                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                    |                 |                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY                                             |                                |                                                                |          |            |  |
| Baltimore                                                                                                                                                                                                                                                                                                     |  | 6 N. Morley St.                                                                                        |  |                                                                                                                                                          |                                                                     | Retired                                                       |                                    |                 |                                                                     | Post Office                                                                   |                                |                                                                |          |            |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          | 13b. COUNTY                                                         |                                                               | 13c. CITY OR TOWN                  |                 | 13d. INSIDE CITY LIMITS?                                            |                                                                               | 13e. STREET ADDRESS / ZIP CODE |                                                                |          |            |  |
| Md.                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               | Balto.                             |                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                               | 6 N. Morley St. 21229          |                                                                |          |            |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME                                            |                                                               |                                    |                 |                                                                     |                                                                               |                                |                                                                |          |            |  |
| Thomas Wilson                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          | Amelia Wilson                                                       |                                                               |                                    |                 |                                                                     |                                                                               |                                |                                                                |          |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          | 16b. SOCIAL SECURITY NO.                                            |                                                               |                                    |                 |                                                                     | 17. INFORMANT ADDRESS                                                         |                                |                                                                |          |            |  |
| Yes                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          | 214-20-9893                                                         |                                                               |                                    |                 |                                                                     | Janet Wilson 6 N. Morley St.                                                  |                                |                                                                |          |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               |                                    |                 |                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |                                |                                                                |          |            |  |
| IMMEDIATE CAUSE (a) <u>inanition</u>                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               |                                    |                 |                                                                     | 3 months                                                                      |                                |                                                                |          |            |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>pancreatic carcinoma</u>                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               |                                    |                 |                                                                     | 18 months                                                                     |                                |                                                                |          |            |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               |                                    |                 |                                                                     |                                                                               |                                |                                                                |          |            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) _____                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               |                                    |                 |                                                                     |                                                                               |                                |                                                                |          |            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                               |                                    |                 |                                                                     | 20a. AUTOPSY?                                                                 |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |            |  |
|                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               |                                    |                 |                                                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                                | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |                                                               |                                    |                 |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                |                                                                |          |            |  |
|                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               |                                    |                 |                                                                     |                                                                               |                                |                                                                |          |            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                               |                                    |                 |                                                                     | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |                                |                                                                |          |            |  |
|                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               |                                    |                 |                                                                     |                                                                               |                                |                                                                |          |            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from Jan 19 85, to May 19 86, that (1) (we) lost saw the deceased alive on 5-21-19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               |                                    |                 |                                                                     |                                                                               |                                |                                                                |          |            |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          | DEGREE                                                              |                                                               |                                    |                 |                                                                     | 22c. DATE SIGNED                                                              |                                |                                                                |          |            |  |
| Teri A Manolidis                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               |                                    |                 |                                                                     | 5/28/86                                                                       |                                |                                                                |          |            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          | 22e. ADDRESS                                                        |                                                               |                                    |                 |                                                                     |                                                                               |                                |                                                                |          |            |  |
| TERI A MANOLIDIS MD                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          | HARVEY 402, JOHNS HOPKINS HOSP                                      |                                                               |                                    |                 |                                                                     |                                                                               |                                |                                                                |          |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          | 23b. DATE                                                           |                                                               | 23c. NAME OF CEMETERY OR CREMATORY |                 |                                                                     | 23d. LOCATION CITY OR TOWN COUNTY STATE                                       |                                |                                                                |          |            |  |
| Burial                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          | 5/2/86                                                              |                                                               | Garrison Forest Vet                |                 |                                                                     | Owings Mills, Md.                                                             |                                |                                                                |          |            |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               |                                    |                 |                                                                     | 24b. DATE REC'D. BY REGISTRAR                                                 |                                | 25b. REGISTRAR'S SIGNATURE                                     |          |            |  |
| Wm C March F/H West                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               |                                    |                 |                                                                     | JUN 3 1986                                                                    |                                | Julia Gordon Hordell                                           |          |            |  |
| ADDRESS                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               |                                    |                 |                                                                     |                                                                               |                                |                                                                |          |            |  |
| 4300 Wabash Ave.                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |                                                                     |                                                               |                                    |                 |                                                                     |                                                                               |                                |                                                                |          |            |  |



RECEIVED  
JAN 11 1900

00-06256

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14313

REG. NO.

|                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                           |                                                                                                                                                      |                                                                  |                                                                                                                                       |                                                                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William M. Wilson, Jr                                                                                                                                                                                                                                                                   |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 7 86                          |                                                                                                                                                             |                                                           | 2b. HOUR<br>12:40 P.M.                                                                                                                               |                                                                  |                                                                                                                                       |                                                                                                 |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br>BLACK                                                                                                                          |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 14 54                                                                                                               |                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>32 YRS.                                                                                                           |                                                                  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                          |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                       |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE City MD                                                                                            |                                                                  |                                                                                                                                       |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Maryland Hospital |                                                                        |                                                                                                                                                             |                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>WASTE DISPOSAL                                                                   |                                                                  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                     |                                                                                                 |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |                                                                        |                                                                                                                                                             | 13b. COUNTY<br>Balt.                                      |                                                                                                                                                      | 13c. CITY OR TOWN<br>Balt.                                       |                                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>William                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                           |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>ESTELLA Young                 |                                                                                                                                                      |                                                                  |                                                                                                                                       |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                     |  |                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br>213/62/1098                                |                                                                                                                                                             |                                                           | 17. INFORMANT<br>ADDRESS<br>William M. Wilson, Sr 6235 Pioneer Drive                                                                                 |                                                                  |                                                                                                                                       |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Brain death<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) intracranial hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) hypertension<br>Approximate interval between onset and death<br>24 hours |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                           |                                                                                                                                                      |                                                                  |                                                                                                                                       |                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                           |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                           |                                                                                                                                                      |                                                                  |                                                                                                                                       |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                           | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                 |                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                       |  |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                       |                                                                  |                                                                                                                                       |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                   |  |                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                  |                                                                                                                                       |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 6, 1986, to May 7, 1986, that (I) (we) last saw the deceased alive on May 7, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.             |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                           |                                                                                                                                                      |                                                                  |                                                                                                                                       |                                                                                                 |  |
| 22b. SIGNATURE<br>John A. Ulatawski MD                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                           | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                  | 22c. DATE SIGNED<br>5-7-86                                                                                                            |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John A. Ulatawski MD                                                                                                                                                                                                                                                                  |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                           | 22e. ADDRESS<br>22 S. Greene St. Balt, Md. 21201                                                                                                     |                                                                  |                                                                                                                                       |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                         |  |                                                                                                                                           | 23b. DATE<br>5/13/86                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel CO MD |                                                                                                                                       |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>March Funeral Home West 4300 Wabash Avenue                                                                                                                                                                                                                                                     |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                           | 25a. DATE REC'D. BY REGISTRAR<br>MAY 12 1986                                                                                                         |                                                                  |                                                                                                                                       |                                                                                                 |  |

MEDICAL CERTIFICATION

12

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or advised.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon copies, page 2 and 3, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked by item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

RELEASED ON APPROVAL BY DR. DIXON PER MR. HENRY

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|-----------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                   |  | 2a. DATE OF DEATH                                                                                      |  | MONTH DAY YEAR                                                                                                                                           |  | 2b. HOUR                                                            |  | P                                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                         |  | FIRST MIDDLE LAST                                                                                      |  | 2a. DATE OF DEATH                                                                                                                                        |  | MONTH DAY YEAR                                                      |  | 2b. HOUR P                                          |  |
| ALLEN RAY WINGATE, Sr.                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | MAY 13, 1986                                                                                                                                             |  |                                                                     |  | 9:10 AM                                             |  |
| 3. SEX                                                                                                                                                                                                                                                                                   |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR                                  |  |
| Male                                                                                                                                                                                                                                                                                     |  | White                                                                                                  |  | March 13, 1923                                                                                                                                           |  | 63 YRS.                                                             |  | MONTHS DAYS HOURS MIN.                              |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | 10. BALTIMORE CITY MD                               |  |
| Maryland                                                                                                                                                                                                                                                                                 |  | U.S.A.                                                                                                 |  |                                                                                                                                                          |  | BALTIMORE CITY                                                      |  |                                                     |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                                     |  |
| BALTIMORE                                                                                                                                                                                                                                                                                |  | THE JOHNS HOPKINS HOSPITAL                                                                             |  | Office Manager                                                                                                                                           |  | Sears                                                               |  |                                                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                             |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS / ZIP CODE                      |  |
| Md.                                                                                                                                                                                                                                                                                      |  | Balto.                                                                                                 |  | Reisterstown                                                                                                                                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 919 Lindellen Ave., 21136                           |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                         |  | 16b. SOCIAL SECURITY NO.                                            |  | 17. INFORMANT                                       |  |
| Phillip Channing Wingate, Sr.                                                                                                                                                                                                                                                            |  | Helen May Carter                                                                                       |  | Yes                                                                                                                                                      |  | WW II                                                               |  | 919 Lindellen Ave., Hilda Wingate Reisterstown, Md. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                |  | PART 1. DEATH WAS CAUSED BY:                                                                           |  | IMMEDIATE CAUSE (a)                                                                                                                                      |  | FAILURE TO WEAN FROM CARDIOPULMONARY BYPASS                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                                                                                                                           |  | (b)                                                                                                    |  | CORONARY ARTERY ATHEROSCLEROSIS                                                                                                                          |  | 5 YRS                                                               |  |                                                     |  |
| (c)                                                                                                                                                                                                                                                                                      |  | DUE TO, OR AS A CONSEQUENCE OF                                                                         |  |                                                                                                                                                          |  |                                                                     |  |                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                                     |  |
| 5/13/86                                                                                                                                                                                                                                                                                  |  | CORONARY ARTERY DISEASE                                                                                |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                       |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                     |  |                                                     |  |
|                                                                                                                                                                                                                                                                                          |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                     |  |                                                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |  |                                                     |  |
|                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-8 1986, to 5-13 1986, that I saw the deceased alive on 5-13 1983, and that in my opinion death occurred on the date and hour and from the causes stated above. (If the deceased did not view the body after death.) |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                     |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                           |  | DEGREE                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED                                                    |  |                                                     |  |
| R. G. G. G.                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  | 5-13-86                                                             |  |                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                    |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                     |  |                                                     |  |
| CNSALE                                                                                                                                                                                                                                                                                   |  | JHH                                                                                                    |  |                                                                                                                                                          |  |                                                                     |  |                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |                                                     |  |
| Burial                                                                                                                                                                                                                                                                                   |  | May 16, 1986                                                                                           |  | Lake View Memorial Park                                                                                                                                  |  | Sykesville, Carroll, Md.                                            |  |                                                     |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |  |                                                                     |  |                                                     |  |
| H. J. Schmitt                                                                                                                                                                                                                                                                            |  | MAY 15 1986                                                                                            |  | John Schmitt                                                                                                                                             |  |                                                                     |  |                                                     |  |

BP



00-00000

March 11, 1933

U.S.A.

Washington

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, U.S. Department of Justice, Washington, D.C.

Dear Sir:

Reference is made to your letter of March 10, 1933, regarding the above captioned matter.



Very respectfully,  
Special Agent in Charge

Very truly yours,  
Special Agent in Charge

Very truly yours,  
Special Agent in Charge

Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                           |  | 86 1/4315<br>REG. NO.                                                                           |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LEON WINIK</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                           |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05-02-86</b> 2b. HOUR <b>12:45</b> M                  |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>WHITE</b>                                                                                                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 23, 1913</b>                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINDALE HEBREW HOME</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BOOKKEEPER</b>                                                                                                                                                                                                                                                                                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>LIQUOR DIST.</b>                                                                                  |  |                                                                                                 |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                           |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ISRAEL NATHAN WINIK</b>                                                                                                                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH UNKNOWN</b>                                                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br><b>216-05-1307A</b>                                                                                           |  | 17. INFORMANT<br><b>MRS. EVA WINIK</b><br>ADDRESS<br><b>6506 HOPETON AVE. BALTO., MD 21215</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEPATIC MALIGNANCY</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>UNKNOWN PRIMARY</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>UNKNOWN PRIMARY</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3-86</b>                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CHRONIC LEUKEMIA</b>                                                                                                                                                                                                                      |  |                                                                                                                                           |  |                                                                                                 |  |
| 19a. DATE OF OPERATION<br><b>5</b>                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4-21-86</b> P.M. 19                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM, ETC.)                                                                       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-21-86</b> to <b>5-2-86</b> , that (I) (we) lost saw the deceased alive on <b>5-2-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                           |  |                                                                                                                                           |  |                                                                                                 |  |
| 22b. SIGNATURE<br><b>B. ZAW-WIN, M.D.</b>                                                                                                                                                                                                                                                                                                                                            |  | DEGREE<br><b>MD</b>                                                                                                                       |  | 22c. DATE SIGNED<br><b>5-2-86</b>                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. ZAW-WIN, M.D.</b>                                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS<br><b>Levinvale Geriatric Ctr BALTO MD 21206</b>                                                                             |  |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>MAY 2, 1986</b>                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH EL MEM. PARK</b>                                  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>RANDALLSTOWN, BALTO. MD</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           |  |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>                                                                                                                                                                                                                                                                                                                |  | ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 6 1986</b>                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>Judith Davidson-Randall</b>                                                                              |  |                                                                                                 |  |



00-06052

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14316

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |                                                      |                                                                                                                                                             |                                                                                      |                                                                                                                            |                                                      |                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Alice C. Winston</b>                                                                                                                                                                                                                                                                            |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/7/86</b> |                                                                                                                                                             | 2b. HOUR<br><b>1:25 PM</b>                                                           |                                                                                                                            |                                                      |                                                                      |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>Black</b>                                                                                                            |                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12/23/06</b>                                                                                                       |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS<br>MONTHS DAYS HOURS MIN.                                                 |                                                      |                                                                      |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                      |                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                          |                                                      |                                                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |                                                      |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Domestic</b> |                                                                      |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY                                                                                                                        |                                                      | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                      | 13e. STREET ADDRESS / ZIP CODE<br><b>1547 Homestead Street 21218</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lee Veney</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edna Campbell</b>                                                                                       |                                                                                      |                                                                                                                            |                                                      |                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Unknown</b>                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br><b>218188195</b>                                                                                       |                                                      | 17. INFORMANT<br>ADDRESS<br><b>Lola Luttrell 1547 Homestead Street</b>                                                                                      |                                                                                      |                                                                                                                            |                                                      |                                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis, source unknown</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>~5 days</b><br><b>~5 days</b> |  |                                                                                                                                    |                                                      |                                                                                                                                                             |                                                                                      |                                                                                                                            |                                                      |                                                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>                                                                                                                                                                                                                     |  |                                                                                                                                    |                                                      |                                                                                                                                                             |                                                                                      |                                                                                                                            |                                                      |                                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                      |                                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                  |                                                      | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                                      |                                                                                                                            |                                                      |                                                                      |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                                                            |                                                      |                                                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/2/86</b> to <b>5/7/86</b> , that (I) (we) last saw the deceased alive on <b>5/7/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                      |  |                                                                                                                                    |                                                      |                                                                                                                                                             |                                                                                      |                                                                                                                            |                                                      |                                                                      |  |
| 22b. SIGNATURE<br><b>Joanna D. Brandt, M.D.</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |                                                      | DEGREE<br><b>M.D.</b>                                                                                                                                       |                                                                                      | 22c. DATE SIGNED<br><b>5/7/86</b>                                                                                          |                                                      |                                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joanna D. Brandt, M.D.</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |                                                      | 22e. ADDRESS<br><b>301 St. Paul Street, Baltimore, MD.</b>                                                                                                  |                                                                                      |                                                                                                                            |                                                      |                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>5/12/86</b>                                                                                                        |                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cemetery</b>                                                                                          |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                                                        |                                                      |                                                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>March Funeral Homes</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |                                                      | ADDRESS<br><b>1101 East North Avenue</b>                                                                                                                    |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 9 1986</b>                                                                         |                                                      |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                                                                                 |                                                                                      |                                                                                                                            |                                                      |                                                                      |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON FIBER

100% COTTON FIBER



00-07056

FOR  
STATE  
REGISTRAR

James William Wise

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14317

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |                                                                               |                                                                                                                                                             |                                                                                           |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James William Wise                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 18 86                                |                                                                                                                                                             |                                                                                           | 2b. HOUR<br>827 P.M.                                                                                                                                 |                                                                                                 |                                                                                                                            |                                                          |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>Cauc.                                                                                                                            |                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 3 42                                                                                                                |                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>44 YRS.                                                                                                           |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Baltimore, Md.                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                         |                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                           |                                                                                                 |                                                                                                                            |                                                          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Medical Ctr. |                                                                               |                                                                                                                                                             |                                                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Yardman                                                                          |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Lumber Co.                                                                            |                                                          |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                             | 13b. COUNTY<br>Baltimore                                                      |                                                                                                                                                             | 13c. CITY OR TOWN<br>Essex                                                                |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br>4 Barnacle Court 21221 |  |
| 14. FATHER'S NAME<br>FIRST "Bud" MIDDLE Wise LAST                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST Margaret MIDDLE Hartlove LAST               |                                                                                                                                                             |                                                                                           |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>66-68 217 40 5035 |                                                                                                                                                             | 17. INFORMANT<br>2321 DORRIS St. Salem Village Rd.<br>George C. Dunn, Brother Balto 21234 |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Gram negative spontaneous bacterial peritonitis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Sepsis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                             |                                                                               |                                                                                                                                                             |                                                                                           |                                                                                                                                                      |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                |  |                                                                                                                                             |                                                                               |                                                                                                                                                             |                                                                                           |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |                                                                                                                                                             |                                                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                           |  |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |                                                                                                                                                             |                                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                        |                                                                                                 |                                                                                                                            |                                                          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |                                                                                                                                                             |                                                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                                 |                                                                                                                            |                                                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/18 19 86, to 5/18 19 86, that (I) (we) last saw the deceased alive on 5/18 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                    |  |                                                                                                                                             |                                                                               |                                                                                                                                                             |                                                                                           |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                          |  |
| 22b. SIGNATURE<br>Lea Stern MD                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                             |                                                                               |                                                                                                                                                             |                                                                                           | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br>5/18/86                                                                                                |                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LEA STERN MD                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             |                                                                               |                                                                                                                                                             |                                                                                           | 22e. ADDRESS<br>4940 Eastern Ave Baltimore MD 21224                                                                                                  |                                                                                                 |                                                                                                                            |                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                             | 23b. DATE<br>5/21/86                                                          |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Memorial Gardens                         |                                                                                                                                                      |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md.                                                           |                                                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Brudzinski Funeral Home                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |                                                                               |                                                                                                                                                             |                                                                                           | 25a. DATE REC'D. BY REGISTRAR<br>MAY 20 1986                                                                                                         |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>John Davidson                                                                                |                                                          |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed with the health department, or with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





0-07073

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 3 1 8  
REG. NO.

|                                                                                             |         |                                                                                             |  |                                                                                                        |  |
|---------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                      |         | 2a. DATE OF DEATH MONTH DAY YEAR                                                            |  | 2b. HOUR                                                                                               |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                            |         | 3. DATE OF BIRTH MONTH DAY YEAR                                                             |  | 4. BALTIMORE CITY OR COUNTY OF DEATH                                                                   |  |
| Martin E. Wise                                                                              |         | 1-25-1900                                                                                   |  | Baltimore City MD.                                                                                     |  |
| 5. SEX                                                                                      | 6. RACE | 7. DATE OF BIRTH MONTH DAY YEAR                                                             |  | 8. BALTIMORE CITY OR COUNTY OF DEATH                                                                   |  |
| male                                                                                        | Col.    | 1-25-1900                                                                                   |  | Baltimore City MD.                                                                                     |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                    |         | 10. CITIZEN OF WHAT COUNTRY?                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |
| Maryland                                                                                    |         | U.S.A.                                                                                      |  | Maryland General Hospital                                                                              |  |
| 12. CITY OR TOWN OF DEATH                                                                   |         | 13. USUAL OCCUPATION (TYPE OF WORK, MOST OF WORKING LIFE)                                   |  | 14. KIND OF BUSINESS OR INDUSTRY                                                                       |  |
| Baltimore                                                                                   |         | Retired                                                                                     |  |                                                                                                        |  |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |         | 16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 17. STREET ADDRESS / ZIP CODE                                                                          |  |
| Maryland                                                                                    |         | YES                                                                                         |  | 1213 N. Bentall St 21216                                                                               |  |
| 18. FATHER'S NAME (FIRST MIDDLE LAST)                                                       |         | 19. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)                                                |  | 20. SOCIAL SECURITY NO.                                                                                |  |
| John T. Wise                                                                                |         | Carrie Elzey                                                                                |  | 816-09-2467                                                                                            |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                            |         | 22. INFORMANT                                                                               |  | 23. ADDRESS                                                                                            |  |
| No                                                                                          |         | Mrs. Ethel M. Wise                                                                          |  | 1213                                                                                                   |  |

|                                                                                                       |  |                                              |  |
|-------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>Acute &amp; Chronic Respiratory Failure 2<sup>o</sup></u>                      |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe End Stage COPD</u>                                       |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                              |  |                                              |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                     |  |                                                                                                                                 |  |                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINERS)                                                                                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                  |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                  |  |                                                                                                                         |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>February 24,</u> 19 <u>86</u> , to <u>May 11,</u> 19 <u>86</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>May 11,</u> 19 <u>86</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) review the body after death. |  |                                                                     |  |                                                                                                                                 |  |                                                                                                                         |  |
| 23a. SIGNATURE OF PHYSICIAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                     |  | DEGREE                                                                                                                          |  | 23c. DATE SIGNED                                                                                                        |  |
| Michael Diamant, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                     |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 5/11/86                                                                                                                 |  |
| 24. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                     |  | 25. ADDRESS                                                                                                                     |  |                                                                                                                         |  |
| Michael Diamant, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                     |  | c/o Maryland General Hospital                                                                                                   |  |                                                                                                                         |  |

|                                           |  |           |  |                                    |  |                                           |  |
|-------------------------------------------|--|-----------|--|------------------------------------|--|-------------------------------------------|--|
| 26a. BURIAL, CREMATION, REMOVAL (SPECIFY) |  | 26b. DATE |  | 26c. NAME OF CEMETERY OR CREMATORY |  | 26d. LOCATION (CITY OR TOWN) COUNTY STATE |  |
| Burial                                    |  | 5-15-86   |  | St. Thomas Cem                     |  | Randallstown Md.                          |  |
| 27. FUNERAL DIRECTOR NAME                 |  |           |  | 28. DATE REC'D. BY REGISTRAR       |  | 29. REGISTRAR'S SIGNATURE                 |  |
| Joseph L. Russ                            |  |           |  | MAY 20 1986                        |  | [Signature]                               |  |
| 30. ADDRESS                               |  |           |  |                                    |  |                                           |  |
| 2222 W. North Ave.                        |  |           |  |                                    |  |                                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

99

BP 17

0-0505

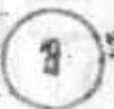
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00-07416

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

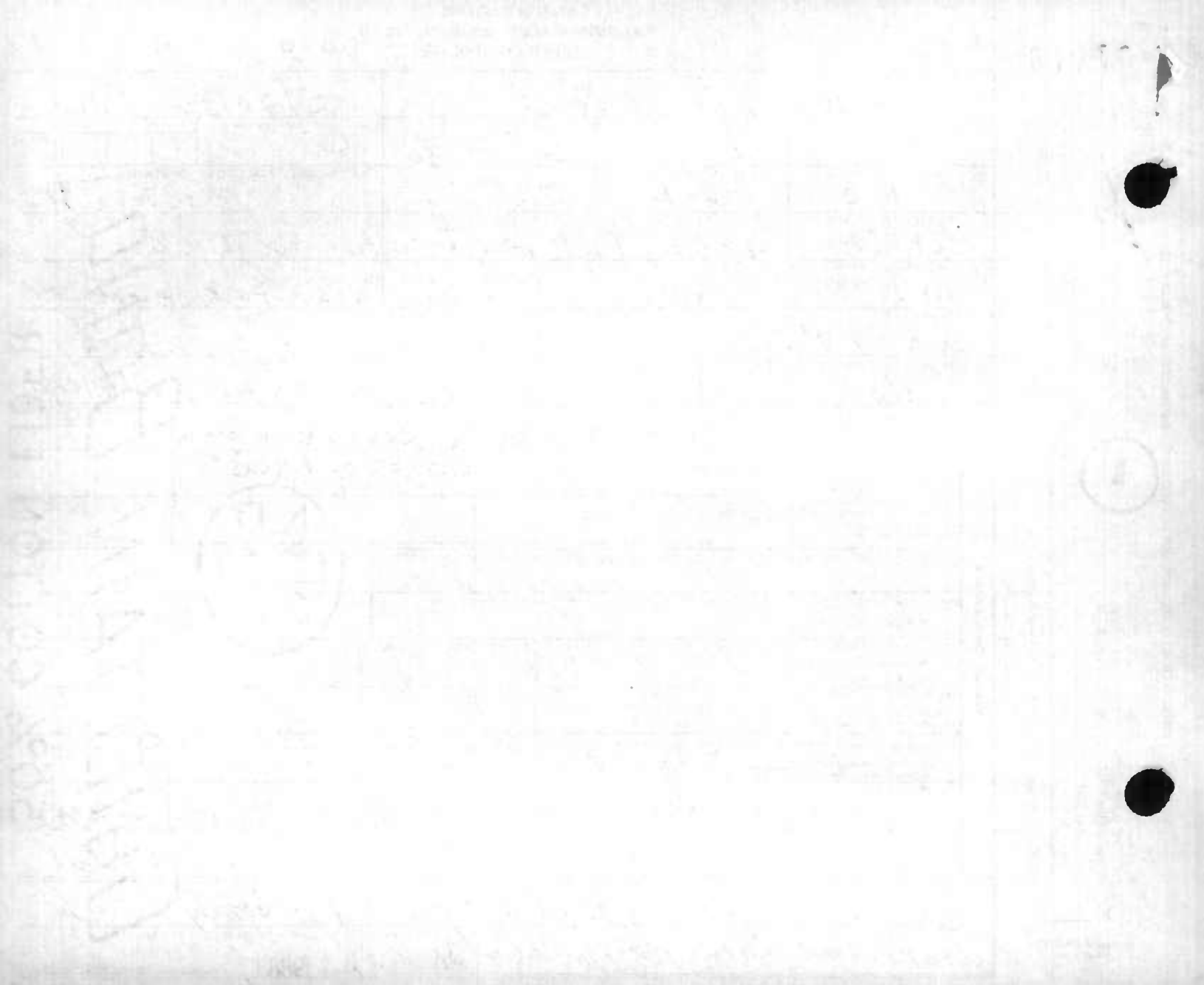
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                     |  | FIRST                                                                                                     |  | MIDDLE                                                                                                                                                   |  | LAST                                                                |  | 2a. DATE OF DEATH MONTH DAY YEAR                               |  | 2b. HOUR                                     |  |
| NANNIE                                                                                                                                                                                                                                                                                                                                                                                  |  | Wise                                                                                                      |  |                                                                                                                                                          |  |                                                                     |  | 5/20/86                                                        |  | 11A M                                        |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE                                                                                                   |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                                                |  | IF UNDER 24 HRS                              |  |
| F                                                                                                                                                                                                                                                                                                                                                                                       |  | N                                                                                                         |  | 6 12 30                                                                                                                                                  |  | 65                                                                  |  | MONTHS DAYS                                                    |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                                                |  |                                              |  |
| N.C.                                                                                                                                                                                                                                                                                                                                                                                    |  | U.S.A.                                                                                                    |  |                                                                                                                                                          |  | Balto. City MD.                                                     |  |                                                                |  |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                                                |  |                                              |  |
| BALTO.                                                                                                                                                                                                                                                                                                                                                                                  |  | 4353 Park Heights Dr                                                                                      |  | Assembly Line G.E.                                                                                                                                       |  |                                                                     |  |                                                                |  |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY                                                                                               |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                                            |  |                                              |  |
| Md                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | BALTO                                                                                                                                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 4353 Park Heights Dr                                           |  |                                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME                                                                                  |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |  |
| WM. Woodard                                                                                                                                                                                                                                                                                                                                                                             |  | PATRIA Richardson                                                                                         |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.                                                                                  |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                             |  |                                                                |  |                                              |  |
| No                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | Deborah YANCY                                                                                                                                            |  | 4353 Park Heights                                                   |  |                                                                |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>TERMINAL CANCER secondary from</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>CANCER OF BREAST</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |                                                                                                           |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                     |  |                                                                                                           |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  |                                                                                                                                                          |  | 20a. AUTOPSY?                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  |                                                                                                                                                          |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                     |  |                                                                |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                        |  |                                                                     |  |                                                                |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  | 11A 85 to 520 19 86                                                                                                                                      |  |                                                                     |  |                                                                |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                          |  | DEGREE                                                                                                    |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED                                                    |  |                                                                |  |                                              |  |
| Kuang-Yen Huang                                                                                                                                                                                                                                                                                                                                                                         |  | M.D.                                                                                                      |  |                                                                                                                                                          |  | 5/23/86                                                             |  |                                                                |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                   |  | 22e. ADDRESS                                                                                              |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |  |
| KUANG-YEN HUANG                                                                                                                                                                                                                                                                                                                                                                         |  | Bon Secours Hospital                                                                                      |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                                                                |  |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                  |  | 5/24/86                                                                                                   |  | Mt. Calvary                                                                                                                                              |  | A.A. County MD.                                                     |  |                                                                |  |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR                                                                             |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |  |                                                                     |  |                                                                |  |                                              |  |
| Locke Funeral Home                                                                                                                                                                                                                                                                                                                                                                      |  | MAY 23 1986                                                                                               |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |                                              |  |

MEDICAL CERTIFICATION



00-09236

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner and the medical examiner's office must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |                   |                                                                     |          |                                                                |     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|---------------------------------------------------------------------|----------|----------------------------------------------------------------|-----|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                    |  | BABY BOY WISSMANN                                                                                      |  |                                                                                                                                                          |                   | 86                                                                  |          | 14320                                                          |     |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          | 2a. DATE OF DEATH |                                                                     | MONTH    |                                                                | DAY |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          | MONTH DAY YEAR    |                                                                     | 2b. HOUR |                                                                |     |
| baby boy Wissmann                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          | 5 30 86           |                                                                     | 8 57 AM  |                                                                |     |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |          | IF UNDER 1 YEAR                                                |     |
| male                                                                                                                                                                                                                                                                                                                                                                                      |  | White                                                                                                  |  | MONTH DAY YEAR                                                                                                                                           |                   | —                                                                   |          | MONTHS DAYS HOURS MIN.                                         |     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |          |                                                                |     |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                 |  | U.S.A.                                                                                                 |  |                                                                                                                                                          |                   | Baltimore City                                                      |          | MD.                                                            |     |
| 11. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |          | 12b. KIND OF BUSINESS OR INDUSTRY                              |     |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                 |  | St. Agnes Hospital                                                                                     |  |                                                                                                                                                          |                   | None                                                                |          | N/A                                                            |     |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |                   | 13d. INSIDE CITY LIMITS?                                            |          | 13e. STREET ADDRESS / ZIP CODE                                 |     |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                  |  | --                                                                                                     |  | Baltimore                                                                                                                                                |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          | 3110 Georgetown Rd - Baltimore 21230                           |     |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                        |                   | 16b. SOCIAL SECURITY NO.                                            |          | 17. INFORMANT                                                  |     |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                         |  | FIRST MIDDLE LAST                                                                                      |  | n/a                                                                                                                                                      |                   | N/A                                                                 |          | Joann Regina Weissman                                          |     |
| unknown                                                                                                                                                                                                                                                                                                                                                                                   |  | Joann Regina Weissman                                                                                  |  |                                                                                                                                                          |                   |                                                                     |          | 3110 Georgetown Road Baltimore, MD. 21230                      |     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                          |                   |                                                                     |          |                                                                |     |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |                   |                                                                     |          |                                                                |     |
| IMMEDIATE CAUSE (a) <u>prematurity - cardiac arrest</u>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                          |                   |                                                                     |          |                                                                |     |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |                   |                                                                     |          |                                                                |     |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |                   |                                                                     |          |                                                                |     |
| (b) <u>Severe prematurity</u>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |                   |                                                                     |          |                                                                |     |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |                   |                                                                     |          |                                                                |     |
| (c)                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |                   |                                                                     |          |                                                                |     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |                   |                                                                     |          |                                                                |     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                          |                   | 20a. AUTOPSY?                                                       |          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |     |
|                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          | YES <input type="checkbox"/> NO <input type="checkbox"/>       |     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |                   |                                                                     |          |                                                                |     |
|                                                                                                                                                                                                                                                                                                                                                                                           |  | HOUR A.M. MONTH DAY YEAR                                                                               |  |                                                                                                                                                          |                   |                                                                     |          |                                                                |     |
|                                                                                                                                                                                                                                                                                                                                                                                           |  | P.M. 19                                                                                                |  |                                                                                                                                                          |                   |                                                                     |          |                                                                |     |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION                                                                                                                                            |                   | CITY OR TOWN                                                        |          | COUNTY STATE                                                   |     |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | STREET                                                                                                                                                   |                   |                                                                     |          |                                                                |     |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6:15 AM 5/30</u> , 19 <u>86</u> , to <u>8:27 5/30/86</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/30 8:27 AM</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |                   |                                                                     |          |                                                                |     |
| 27b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                            |  | DEGREE                                                                                                 |  |                                                                                                                                                          |                   | 27c. DATE SIGNED                                                    |          |                                                                |     |
| <u>Sharif</u>                                                                                                                                                                                                                                                                                                                                                                             |  | Resident                                                                                               |  |                                                                                                                                                          |                   | 5/30/86                                                             |          |                                                                |     |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                     |  | 27e. ADDRESS                                                                                           |  |                                                                                                                                                          |                   |                                                                     |          |                                                                |     |
| Mounther                                                                                                                                                                                                                                                                                                                                                                                  |  | sharif                                                                                                 |  |                                                                                                                                                          |                   | St. Agnes Hospital, Baltimore, MD.                                  |          |                                                                |     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                   | 23d. LOCATION                                                       |          | CITY OR TOWN COUNTY STATE                                      |     |
| Burial                                                                                                                                                                                                                                                                                                                                                                                    |  | 6/9/86                                                                                                 |  | New Cathedral                                                                                                                                            |                   | Baltimore                                                           |          | MD.                                                            |     |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR                                                                          |  |                                                                                                                                                          |                   | 25b. REGISTRAR'S SIGNATURE                                          |          |                                                                |     |
| NAME                                                                                                                                                                                                                                                                                                                                                                                      |  | JUN 12 1986                                                                                            |  |                                                                                                                                                          |                   | Julia Davidson-Rodgers                                              |          |                                                                |     |
| Leroy and Russell Witzke Funl Home                                                                                                                                                                                                                                                                                                                                                        |  | 1630 Edmondson Ave Catonsville, MD. 21228                                                              |  |                                                                                                                                                          |                   |                                                                     |          |                                                                |     |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

14321

|                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |                                                                                           |                                                                                                                                                            |                                                                        |                                                                                                                                            |                                                                                                |                                                                                                                           |                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>CATHERINE M. WITT</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                       | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>05 19 1986</b>                                   |                                                                                                                                                            |                                                                        | 2b HOUR<br><b>2:20</b> PM                                                                                                                  |                                                                                                |                                                                                                                           |                                                                    |  |
| 3 SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 4 RACE<br><b>WHITE</b>                                                                                                                |                                                                                           | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 26 19</b>                                                                                                       |                                                                        | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                                                                           |                                                                                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                          |                                                                    |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                            |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |                                                                                           | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                        | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                           |                                                                                                |                                                                                                                           |                                                                    |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                           |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |                                                                                           |                                                                                                                                                            |                                                                        | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                        |                                                                                                | 12b KIND OF BUSINESS OR INDUSTRY<br><b>---</b>                                                                            |                                                                    |  |
| 13a STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                       | 13b COUNTY                                                                                |                                                                                                                                                            | 13c CITY OR TOWN<br><b>Baltimore</b>                                   |                                                                                                                                            | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                           | 13e STREET ADDRESS / ZIP CODE<br><b>2915 Stafford Street 21223</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Beutelspacher</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unknown Gloga</b>                      |                                                                                                                                                            |                                                                        |                                                                                                                                            |                                                                                                |                                                                                                                           |                                                                    |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       | 16b SOCIAL SECURITY NO.<br><b>212-09-2591</b>                                             |                                                                                                                                                            | 17 INFORMANT ADDRESS<br><b>Clayton H. Witt 2915 Stafford St. 21223</b> |                                                                                                                                            |                                                                                                |                                                                                                                           |                                                                    |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiogenic arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>b) <u>sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>c) <u>metastatic lung cancer</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                       |                                                                                           |                                                                                                                                                            |                                                                        |                                                                                                                                            |                                                                                                |                                                                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                     |  |                                                                                                                                       |                                                                                           |                                                                                                                                                            |                                                                        |                                                                                                                                            |                                                                                                |                                                                                                                           |                                                                    |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                           |                                                                                                                                                            |                                                                        | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                        |                                                                                                | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                    |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                |  |                                                                                                                                       | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b> P.M.                          |                                                                                                                                                            |                                                                        | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                               |                                                                                                |                                                                                                                           |                                                                    |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                               |  |                                                                                                                                       | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                     |                                                                                                                                                            |                                                                        | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                           |                                                                                                |                                                                                                                           |                                                                    |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>5/6</u> , 19 <u>86</u> , to <u>5/19</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/19</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |                                                                                                                                       |                                                                                           |                                                                                                                                                            |                                                                        |                                                                                                                                            |                                                                                                |                                                                                                                           |                                                                    |  |
| 22b SIGNATURE<br><i>Michael Enoch</i>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       | DEGREE                                                                                    |                                                                                                                                                            |                                                                        | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                |                                                                                                                           | 22c DATE SIGNED<br><b>5/20/86</b>                                  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Enoch</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                       | 22e ADDRESS<br><b>St. Agnes Hospital<br/>900 S. Caton Avenue Baltimore Maryland 21229</b> |                                                                                                                                                            |                                                                        |                                                                                                                                            |                                                                                                |                                                                                                                           |                                                                    |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       | 23b DATE<br><b>5/22/86</b>                                                                |                                                                                                                                                            | 23c NAME OF CEMETERY OR CREMATORY<br><b>Loudon park Cemetery</b>       |                                                                                                                                            |                                                                                                | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                                                    |                                                                    |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       | ADDRESS<br><b>4107 Wilkens Ave. 21229</b>                                                 |                                                                                                                                                            |                                                                        | 25a MAY 21 1986<br>BY REGISTRAR                                                                                                            |                                                                                                | 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                           |                                                                    |  |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give the permit to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or any traumatic event, the medical examiner must be notified at once.



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YAM

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

14322

|                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |                                                                                        |                                                                                                                                                             |                                                                               |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                       |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES M. WOLF</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 / 5 / 86</b>                               |                                                                                                                                                             |                                                                               | 2b. HOUR<br><b>905 AM</b>                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                       |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>W</b>                                                                                                                           |                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 24 24</b>                                                                                                        |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.                                                                                                    |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.                                                              |                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |                                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                                    |                                                                                                 |                                                                                                                            |                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LOCH RAVEN V. A. HOSPITAL</b> |                                                                                        |                                                                                                                                                             |                                                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED JEWELER</b>                                                           |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>JEWELER</b>                                                                        |                                                                       |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                               | 13b. COUNTY                                                                            |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                         |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br><b>222 B STONECROFT RD. / 21229</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles M. Wolf Sr.</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                               |                                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Brunner</b>               |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                               | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>1943-1945 183-24-6752</b> |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>M's PHYLLIS WOLF 222 B Stonecroft Rd 21229</b> |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>esophageal carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                               |                                                                                        |                                                                                                                                                             |                                                                               |                                                                                                                                                      |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                             |  |                                                                                                                                               |                                                                                        |                                                                                                                                                             |                                                                               |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                       |  |
| 19a. DATE OF OPERATION<br><b>—</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>                           |                                                                                                                                                             |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                            |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                       |  |                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                      |                                                                                                                                                             |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                       |                                                                                                 |                                                                                                                            |                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                      |  |                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |                                                                                                                                                             |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                                 |                                                                                                                            |                                                                       |  |
| 22a. I certify that (2) (this hospital) attended the deceased from <b>April 1, 1986</b> to <b>May 5, 1986</b> , that (1) (we) last saw the deceased alive on <b>May 5, 1986</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. <del>(we) (did) not view the body after death.</del>                                         |  |                                                                                                                                               |                                                                                        |                                                                                                                                                             |                                                                               |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                                                       |  |
| 22b. SIGNATURE<br><b>B. Aristimuño MD</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               |                                                                                        |                                                                                                                                                             |                                                                               | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>5/5/86</b>                                                                                          |                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BEGOÑA ARISTIMUÑO</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |                                                                                        |                                                                                                                                                             |                                                                               | 22e. ADDRESS<br><b>LOCH RAVEN V.A. HOSPITAL</b>                                                                                                      |                                                                                                 |                                                                                                                            |                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               | 23b. DATE<br><b>May 6, 1986</b>                                                        |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial Park</b>           |                                                                                                                                                      |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Balto., Maryland</b>                                          |                                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Harry H Witzke &amp; Family Funeral Home Inc. 4112 Old Columbia Pike Ellicott City</b>                                                                                                                                                                                                                                                      |  |                                                                                                                                               |                                                                                        |                                                                                                                                                             |                                                                               | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 9 1986</b>                                                                                                   |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                           |                                                                       |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

20% Cotton Fiber

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at the time of death.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 3 2 3  
REG. NO.

|                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |                                                       |                                                                                                                                                             |                                             |                                                                                      |  |                                                                                                                            |  |                                                                                                 |  |                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Laura L. Wolf</b>                                                                                                                                                                                                                                           |  |                                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-22-86</b> |                                                                                                                                                             | 2b. HOUR<br>MIN.<br><b>9<sup>30</sup></b> M |                                                                                      |  |                                                                                                                            |  |                                                                                                 |  |                                                                   |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>White</b>                                                                                                                          |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 1 1905</b>                                                                                                     |                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>81</b>                                 |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>81</b>                                                                             |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>9<sup>30</sup></b>                                      |  |                                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                    |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |                                                                                                                            |  |                                                                                                 |  |                                                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General Hospt.</b> |                                                       |                                                                                                                                                             |                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                       |  |                                                                                                 |  |                                                                   |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |                                                       |                                                                                                                                                             |                                             | 13b. COUNTY<br><b>Balto.</b>                                                         |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>348 Ilchester Ave. 21218</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lynn J. Gilbert</b>                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Schaefer</b>                                                                                       |                                             |                                                                                      |  |                                                                                                                            |  |                                                                                                 |  |                                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br><b>212-07-7449</b>                                                                                                   |                                                       | 17. INFORMANT<br>ADDRESS<br><b>Ralph S. Wolf Cockeysville, Md.</b>                                                                                          |                                             |                                                                                      |  |                                                                                                                            |  |                                                                                                 |  |                                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>INTRACEREBRAL HEMORRHAGE</b>                                                                                                                                                            |  |                                                                                                                                                  |                                                       |                                                                                                                                                             |                                             |                                                                                      |  |                                                                                                                            |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Hours</b>                                 |  |                                                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ATHEROSCLEROTIC CEREAL VASCULOPATHY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                |  |                                                                                                                                                  |                                                       |                                                                                                                                                             |                                             |                                                                                      |  |                                                                                                                            |  | <b>7 years</b>                                                                                  |  |                                                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                       |  |                                                                                                                                                  |                                                       |                                                                                                                                                             |                                             |                                                                                      |  |                                                                                                                            |  |                                                                                                 |  |                                                                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |                                                       |                                                                                                                                                             |                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                 |  |                                                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |                                             |                                                                                      |  |                                                                                                                            |  |                                                                                                 |  |                                                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                           |                                                       | 21f. LOCATION<br>STREET<br><b>19</b>                                                                                                                        |                                             | CITY OR TOWN<br><b>19</b>                                                            |  | COUNTY<br><b>19</b>                                                                                                        |  | STATE<br><b>19</b>                                                                              |  |                                                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/22/86</b> to <b>5/22/86</b> , that (I) (we) last saw the deceased alive on <b>5/22/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |                                                                                                                                                  |                                                       |                                                                                                                                                             |                                             |                                                                                      |  |                                                                                                                            |  |                                                                                                 |  |                                                                   |  |
| 22b. SIGNATURE<br><b>B. A. Cockran, MD</b>                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |                                                       | DEGREE<br><b>MD</b>                                                                                                                                         |                                             |                                                                                      |  | 22c. DATE SIGNED<br><b>5/23/86</b>                                                                                         |  |                                                                                                 |  |                                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. A. Cockran, MD</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |                                                       | 22e. ADDRESS<br><b>6506 PARK HEIGHTS AVE, BALTO, 21215</b>                                                                                                  |                                             |                                                                                      |  |                                                                                                                            |  |                                                                                                 |  |                                                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>5-27-86</b>                                                                                                                      |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>                                                                                                    |                                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville Balto. Md.</b>           |  |                                                                                                                            |  |                                                                                                 |  |                                                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co., Balto., Md.</b>                                                                                                                                                                                                                                |  |                                                                                                                                                  |                                                       |                                                                                                                                                             |                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 28 1986</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Funeral Director</b>                                                                      |  |                                                                                                 |  |                                                                   |  |

BP



00-06053

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                  |                                                 |                                                                                                                                                             |                  |                                                                                                 |  |                                                                                                     |  | REG. NO. 1 4 3 2 4                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|----------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Albert Wornack                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                  |                                                 |                                                                                                                                                             |                  |                                                                                                 |  |                                                                                                     |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>5/ 5/ 19 86 |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 28 53                                                                                    | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>32 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                    | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5/ 5/ 19 86                                       |  | 2d. HOUR<br>6:52 P M                                                                                |  |                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           |                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |                                                                                                     |  |                                                          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                               |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>644 W. Hoffman St. |                                                 |                                                                                                                                                             |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Park & Rec.                                                    |  |                                                          |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                               |                  | 13b. COUNTY                                                                                                                      |                                                 | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>644 West Hoffman St. 21201                                                   |  |                                                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Arkle Wornack                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                  |                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ophelia Truesdale                                                                                          |                  |                                                                                                 |  |                                                                                                     |  |                                                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                          |                  | 16b. SOCIAL SECURITY NO.<br>215-40-7187                                                                                          |                                                 | 17. INFORMANT ADDRESS<br>Lillian Coleman 2902 Denham Circle                                                                                                 |                  |                                                                                                 |  |                                                                                                     |  |                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |                                                                                                                                  |                                                 |                                                                                                                                                             |                  |                                                                                                 |  |                                                                                                     |  |                                                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Cirrhosis of the Liver</u>                                                                                                                                                                                                                                  |                  |                                                                                                                                  |                                                 |                                                                                                                                                             |                  |                                                                                                 |  |                                                                                                     |  |                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                               |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                |                                                 |                                                                                                                                                             |                  |                                                                                                 |  | 20. AUTOPSY?<br>PARTIAL ABDO<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                               |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                       |                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>2                                                                          |                  |                                                                                                 |  |                                                                                                     |  |                                                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                         |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                      |                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                  |                                                                                                 |  |                                                                                                     |  |                                                          |  |
| 22. I certify that I took charge of the body and that the death resulted from:<br>Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER<br>DATE SIGNED 5/6/86                                    |                  |                                                                                                                                  |                                                 |                                                                                                                                                             |                  |                                                                                                 |  |                                                                                                     |  |                                                          |  |
| ACTUAL SIGNATURE _____<br>EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                  |                                                 |                                                                                                                                                             |                  |                                                                                                 |  |                                                                                                     |  |                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                  |                  | 23b. DATE<br>5/10/86                                                                                                             |                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cemetery                                                                                                 |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                    |  |                                                                                                     |  |                                                          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>March Funeral Homes 1101 East North Avenue                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                  |                                                 | 25a. DATE REC'D. BY REGISTRAR<br>MAY 9 1986                                                                                                                 |                  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Hendall                                            |  |                                                                                                     |  |                                                          |  |

ALX COLLECTIBLES

2111 1/2 ST. N. ST. LOUIS, MO. 63104


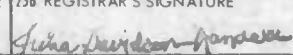




00-08350

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 4 3 2 5

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                     |                                                                                                                    |                                                                                                                                                             |                                                   |                                                                                                                     |                                                                                     |                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Fred D. Woodfolk</b>                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                     | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>5/ 31/ 19 86</b> |                                                                                                                                                             |                                                   | 2b. HOUR <b>7:38</b>                                                                                                |                                                                                     |                                                                    |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                    | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>18</b> YEAR <b>1929</b>                                                                   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>56</b> YRS.                                                                  | IF UNDER 1 YR.<br>MONTHS <b>5</b> DAYS <b>31</b>                                                                                                            | IF UNDER 24 HRS.<br>HOURS <b>19</b> MIN <b>86</b> | 2c. DATE PRONOUNCED DEAD <b>5/ 31/ 19 86</b>                                                                        |                                                                                     |                                                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va</b>                                                                                                                                                                                                                                                                                                                                                                                   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                                                                        |                                                                                                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b>                                                      |                                                                                     |                                                                    |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                            |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |                                                                                                                    |                                                                                                                                                             |                                                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                       |                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Donald B. Tire Company</b> |
| 13a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 13b. COUNTY                                                                                                                         |                                                                                                                    | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |                                                                                     | 13e. STREET ADDRESS<br><b>2912 Woodland Avenue 21215</b>           |
| 14. FATHER'S NAME<br>FIRST <b>David</b> MIDDLE LAST <b>Woodfolk</b>                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                     |                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mable</b> MIDDLE LAST <b>Woodfolk</b>                                                                                  |                                                   |                                                                                                                     |                                                                                     |                                                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                       |                         | 16b. SOCIAL SECURITY NO.<br><b>220-24-7293</b>                                                                                      |                                                                                                                    | 17. INFORMANT ADDRESS<br><b>Sonia Woodfolk 2912 Woodland Avenue</b>                                                                                         |                                                   |                                                                                                                     |                                                                                     |                                                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>(c)                                                                    |                         |                                                                                                                                     |                                                                                                                    |                                                                                                                                                             |                                                   |                                                                                                                     |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                     |                                                                                                                    |                                                                                                                                                             |                                                   |                                                                                                                     |                                                                                     |                                                                    |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                   |                                                                                                                    |                                                                                                                                                             |                                                   |                                                                                                                     | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                    |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                   |                                                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |                                                   |                                                                                                                     |                                                                                     |                                                                    |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                         |                                                                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                   |                                                                                                                     |                                                                                     |                                                                    |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |                                                                                                                                     |                                                                                                                    |                                                                                                                                                             |                                                   |                                                                                                                     |                                                                                     |                                                                    |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                  |                         | TITLE (SPECIFY)<br><b>M.D. Assistant</b>                                                                                            |                                                                                                                    |                                                                                                                                                             |                                                   |                                                                                                                     | DATE SIGNED<br><b>5/31/86</b>                                                       |                                                                    |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                      |                         | ADDRESS <b>111 Penn St.</b>                                                                                                         |                                                                                                                    |                                                                                                                                                             |                                                   |                                                                                                                     |                                                                                     |                                                                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                               |                         | 23b. DATE<br><b>6/5/86</b>                                                                                                          |                                                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>                                                                                            |                                                   | 23d. LOCATION<br>CITY OR TOWN <b>Anne Arundel Co</b> COUNTY <b>MD</b> STATE                                         |                                                                                     |                                                                    |
| 24. FUNERAL DIRECTOR<br>NAME <b>March Funeral Home West 4300 Wabash Avenue</b> ADDRESS                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                     |                                                                                                                    | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 3 1986</b>                                                                                                          |                                                   | 25b. REGISTRAR'S SIGNATURE<br> |                                                                                     |                                                                    |

DIVISION OF VITAL RECORDS, 201 W. PATTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PATTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))

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WATKINS



00-05755

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                |  |                                                                                                                                                             |                                               |                                                                                                 |                     |                                                                           |  | 86                                                                                                                         | 14326 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|-------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                |  |                                                                                                                                                             |                                               |                                                                                                 |                     |                                                                           |  | REG. NO.                                                                                                                   |       |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Bertha M Woolford                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 1 86 |                                                                                                 | 2b. HOUR<br>6:15 AM |                                                                           |  |                                                                                                                            |       |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>Black                                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 9 35                                                                                                                |                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS                                                       |                     | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                              |  |                                                                                                                            |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                                           |                     |                                                                           |  |                                                                                                                            |       |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Under Secretary of Maryland Hospital |  |                                                                                                                                                             |                                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |                     | 12b. KIND OF BUSINESS OR INDUSTRY                                         |  |                                                                                                                            |       |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                |  | 13c. CITY OR TOWN<br>Dorchester Cambridge                                                                                                                   |                                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                     | 13e. STREET ADDRESS / ZIP CODE<br>1012 Camelia Circle 21613               |  |                                                                                                                            |       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Oscar Crager                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Bowdle                                                                                              |                                               |                                                                                                 |                     |                                                                           |  |                                                                                                                            |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>214-305351                                                                                                                      |                                               | 17. INFORMANT ADDRESS                                                                           |                     |                                                                           |  |                                                                                                                            |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Myeloma<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Pathologic Fractures<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <input checked="" type="checkbox"/><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Renal Failure |  |                                                                                                                                                |  |                                                                                                                                                             |                                               |                                                                                                 |                     |                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |       |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |  |                                                                                                                                                             |                                               |                                                                                                 |                     |                                                                           |  |                                                                                                                            |       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                               |                                                                                                 |                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                     |                                                                           |  |                                                                                                                            |       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                     |                                                                           |  |                                                                                                                            |       |
| 22a. I certify that (I) (this hospital) attended the deceased from April 22, 1986, to May 1, 1986, that (I) (we) last saw the deceased alive on May 1, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                                   |  |                                                                                                                                                |  |                                                                                                                                                             |                                               |                                                                                                 |                     |                                                                           |  |                                                                                                                            |       |
| 22b. SIGNATURE<br>Russell R. DeLuca MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                |  |                                                                                                                                                             |                                               |                                                                                                 |                     | 22c. DATE SIGNED<br>5/1/86                                                |  | 22d. ADDRESS<br>22 South Greene Street                                                                                     |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                |  | 23b. DATE<br>5/5/86                                                                                                                                         |                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Woolford Ceme                                             |                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cambridge Dorchester Md.    |  |                                                                                                                            |       |
| 24. FUNERAL DIRECTOR<br>NAME<br>Stewart Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                |  |                                                                                                                                                             |                                               | 25a. DATE REC'D. BY REGISTRAR<br>MAY 6 1986                                                     |                     | 25b. REGISTRAR'S SIGNATURE<br>John W. ...                                 |  |                                                                                                                            |       |

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00-07971

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

1 4 3 2 7

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                            |                                                                       |                                                                                                                                                                           |                                       |                                                                           |                                                                                                 |                                                                                                                            |                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Harden</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 28, 1986</b>            |                                                                                                                                                                           |                                       | 2b. HOUR<br>M                                                             |                                                                                                 |                                                                                                                            |                                                                       |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>Black</b>                                                                                                                    |                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>77 06 1905</b>                                                                                                                   |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>                              |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                 |                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>               |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.         |                                                                                                 |                                                                                                                            |                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2447 Druid Hill Avenue</b> |                                                                       |                                                                                                                                                                           |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                            | 13b. COUNTY                                                           |                                                                                                                                                                           | 13c. CITY OR TOWN<br><b>Baltimore</b> |                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br><b>2447 Druid Hill Avenue 21217</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Wooten</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Dillard</b> |                                                                                                                                                                           |                                       |                                                                           |                                                                                                 |                                                                                                                            |                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>n/a</b>                                                                     |                                                                       | 17. INFORMANT<br>ADDRESS<br><b>21207</b>                                                                                                                                  |                                       | 17. INFORMANT<br>ADDRESS<br><b>21207</b>                                  |                                                                                                 |                                                                                                                            |                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>n/a</b>                                                                     |                                                                       | 17. INFORMANT<br>ADDRESS<br><b>21207</b>                                                                                                                                  |                                       | 17. INFORMANT<br>ADDRESS<br><b>21207</b>                                  |                                                                                                 |                                                                                                                            |                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ascd</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>1 year</b> |  |                                                                                                                                            |                                                                       |                                                                                                                                                                           |                                       |                                                                           |                                                                                                 |                                                                                                                            |                                                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>cold</b> ; <b>UTI</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                            |                                                                       |                                                                                                                                                                           |                                       |                                                                           |                                                                                                 |                                                                                                                            |                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |                                                                       |                                                                                                                                                                           |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                          |                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                            |                                       |                                                                           |                                                                                                 |                                                                                                                            |                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                         |                                       |                                                                           |                                                                                                 |                                                                                                                            |                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-10</b> , 19 <b>81</b> , to <b>5-28</b> , 19 <b>86</b> , that (I) <b>last</b> saw the deceased alive on <b>5-1</b> , 19 <b>86</b> , and that in <b>my</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>viewed</b> did not view the body after death.                                                                                        |  |                                                                                                                                            |                                                                       |                                                                                                                                                                           |                                       |                                                                           |                                                                                                 |                                                                                                                            |                                                                       |  |
| 22b. SIGNATURE<br><b>H. J. SHAFI</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                            |                                                                       | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |                                       |                                                                           |                                                                                                 | 22c. DATE SIGNED<br><b>5/29/86</b>                                                                                         |                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Javaid M SHAFI</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                            |                                                                       | 22e. ADDRESS<br><b>2300 garrison Bld 21216.</b>                                                                                                                           |                                       |                                                                           |                                                                                                 |                                                                                                                            |                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE<br><b>5/31/86</b>                                                                                                                |                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maryland Nat. Cem</b>                                                                                                            |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>         |                                                                                                 |                                                                                                                            |                                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leroy O. Dyett</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                            |                                                                       | 4600 Lib. Heights Ave.                                                                                                                                                    |                                       | 25a. DATE REC'D BY REGISTRAR<br><b>MAY 29 1986</b>                        |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                           |                                                                       |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP



00-08201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate signed 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic or unusual condition, the medical examiner must be notified and a necropsy performed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |  |                                                                                                                                                         |                                                 |                                                                                             |                        |                                                                                                                        |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             |  |                                                                                                                                                         |                                                 |                                                                                             |                        |                                                                                                                        |                                              |
| 1 DECEASED NAME (TYPE OR PRINT) <b>GEORGIA WORKMAN</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             |  |                                                                                                                                                         | 2a DATE OF DEATH MONTH DAY YEAR <b>05 29 86</b> |                                                                                             | 2b HOUR <b>7:03 PM</b> |                                                                                                                        |                                              |
| 3 SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                                     |  | 4 RACE <b>B</b>                                                                                                                             |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>10 04 08</b>                                                                                                         |                                                 | 6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS                                                |                        | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.                                                                                 |                                              |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>                                                                                                                                                                                                                                                                                                                    |  | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                 | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>                               |                        |                                                                                                                        |                                              |
| 10 CITY OR TOWN OF DEATH <b>BALTIMORE CITY</b>                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hosp.</b> |  |                                                                                                                                                         |                                                 | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired -</b>               |                        | 12b KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>                                                                                                                                                                                                                                                             |  | 13b COUNTY <b>BALTIMORE</b>                                                                                                                 |  | 13c CITY OR TOWN <b>BALTIMORE</b>                                                                                                                       |                                                 | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                        | 13e STREET ADDRESS / ZIP CODE <b>3928 GRANTLEY RD. 21215</b>                                                           |                                              |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>MARSHALL</b>                                                                                                                                                                                                                                                                                                                      |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSIE WRIGHT</b>                                                                               |  |                                                                                                                                                         |                                                 |                                                                                             |                        |                                                                                                                        |                                              |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNK.</b>                                                                                                                                                                                                                                                                                            |  | 16b SOCIAL SECURITY NO. <b>239 072155</b>                                                                                                   |  | 17 INFORMANT ADDRESS <b>ANNA WILKINS 3928 Grantley Rd.</b>                                                                                              |                                                 |                                                                                             |                        |                                                                                                                        |                                              |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPSIS</b>                                                                                                                                                                                                                                  |  |                                                                                                                                             |  |                                                                                                                                                         |                                                 |                                                                                             |                        |                                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA.</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |  |                                                                                                                                                         |                                                 |                                                                                             |                        |                                                                                                                        |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |  |                                                                                                                                                         |                                                 |                                                                                             |                        |                                                                                                                        |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                      |  |                                                                                                                                             |  |                                                                                                                                                         |                                                 |                                                                                             |                        |                                                                                                                        |                                              |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                             |  |                                                                                                                                                         |                                                 | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                        | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                       |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19 86</b>                                                                                    |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                                                 |                                                                                             |                        |                                                                                                                        |                                              |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                          |  | 21f LOCATION CITY OR TOWN COUNTY STATE                                                                                                                  |                                                 |                                                                                             |                        |                                                                                                                        |                                              |
| 22a I certify that (I) (this hospital) attended the deceased from <b>MAY 28</b> , 19 <b>86</b> , to <b>MAY 29</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>MAY 29</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                             |  |                                                                                                                                                         |                                                 |                                                                                             |                        |                                                                                                                        |                                              |
| 22b SIGNATURE <b>Leonard Lamont M.D.</b>                                                                                                                                                                                                                                                                                                                                |  | DEGREE <b>MD</b>                                                                                                                            |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |                                                 |                                                                                             |                        | 22c DATE SIGNED <b>5-29-86</b>                                                                                         |                                              |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Leonard Lamont M.D.</b>                                                                                                                                                                                                                                                                                                         |  | 22e ADDRESS <b>3001 S. Hanover St. Baltimore MD 21202</b>                                                                                   |  |                                                                                                                                                         |                                                 |                                                                                             |                        |                                                                                                                        |                                              |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                  |  | 23b DATE <b>6-5-86</b>                                                                                                                      |  | 23c NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>                                                                                                 |                                                 | 23d LOCATION CITY OR TOWN COUNTY STATE <b>Balto., MD.</b>                                   |                        |                                                                                                                        |                                              |
| 24 FUNERAL DIRECTOR NAME <b>Calvin B. SCRUBGES</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |  | ADDRESS <b>1412 E. Preston St.</b>                                                                                                                      |                                                 | 25a DATE REC'D. BY REGISTRAR <b>02 1986</b>                                                 |                        | 25b REGISTRAR'S SIGNATURE <b>John Davidson</b>                                                                         |                                              |



10530-7

UNITED STATES

OWD

100% COTTON

WAVE



00-05533

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 4 3 2 9

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                 |  |                                                                                                                                                             |                               |                                                                                                 |                                |                                                                                              |                                          |                                                 |                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------|-------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | FIRST<br>WILSON                                                                                                                 |  | MIDDLE                                                                                                                                                      |                               | LAST<br>WORRELL, SR.                                                                            |                                | 2b. DATE . KNOWN<br>OF<br>DEATH ESTI-<br>MATED <input checked="" type="checkbox"/> 5 2 19 86 |                                          | 2b. HOUR<br>M                                   |                         |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE<br>black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 30 1919                                                                                 |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>66 YRS.                                                                                                               | IF UNDER 1 YR.<br>MONTHS DAYS |                                                                                                 | IF UNDER 24 HRS.<br>HOURS MIN. |                                                                                              | 2c. DATE<br>PRONOUNCED<br>DEAD 5 2 19 86 |                                                 | 2d. HOUR<br>7:10<br>A M |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Va                                                                                                                                                                                                                                                                                                                                                                                                    |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                |                                                                                              |                                          |                                                 |                         |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2301 Wichita Ave. |  |                                                                                                                                                             |                               | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Contract                    |                                | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                                         |                                          |                                                 |                         |
| 13a. STATE<br>Md                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 13b. COUNTY                                                                                                                     |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                | 13e. STREET ADDRESS<br>2301 Wichita Avenue 21215                                             |                                          |                                                 |                         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Willie Worrell                                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maud Delotch                                                                                               |                               |                                                                                                 |                                |                                                                                              |                                          |                                                 |                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                                                                          |                  | (IF YES, GIVE WAR OR DATES)                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>214-14-5192                                                                                                                     |                               | 17. INFORMANT<br>ADDRESS<br>Vastina Fairfax 2301 Wichita Avenue                                 |                                |                                                                                              |                                          |                                                 |                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-lying cause last.</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                 |                  |                                                                                                                                 |  |                                                                                                                                                             |                               |                                                                                                 |                                |                                                                                              |                                          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                 |  |                                                                                                                                                             |                               |                                                                                                 |                                |                                                                                              |                                          |                                                 |                         |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |                               |                                                                                                 |                                | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |                                          |                                                 |                         |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                                |                                                                                              |                                          |                                                 |                         |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                 |                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                |                                                                                              |                                          |                                                 |                         |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |                  |                                                                                                                                 |  |                                                                                                                                                             |                               |                                                                                                 |                                |                                                                                              |                                          |                                                 |                         |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                 |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                                                                                                          |                               |                                                                                                 |                                | DATE SIGNED 5-2-86                                                                           |                                          |                                                 |                         |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                 |  | ADDRESS<br>111 Penn St., Balto., MD 21201                                                                                                                   |                               |                                                                                                 |                                |                                                                                              |                                          |                                                 |                         |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                |                  | 23b. DATE<br>5/6/86                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest Vet                                                                                                   |                               | 23d. LOCATION<br>CITY OR TOWN<br>Owings Mills MD                                                |                                |                                                                                              |                                          |                                                 |                         |
| 24. FUNERAL DIRECTOR<br>NAME<br>March Funeral Home West 4300 Wabash Avenue                                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                 |  |                                                                                                                                                             |                               | 25a. DATE REC'D. BY REGISTRAR<br>MAY 5 1986                                                     |                                | 25b. REGISTRAR'S SIGNATURE<br>                                                               |                                          |                                                 |                         |

*[Faint, mostly illegible text from a memorandum or letter, possibly containing a list of items or a report.]*

*[Handwritten notes or signatures in the right margin, including what appears to be a signature.]*



00-07476

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14330

|                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                            |  |                                                                                                                                                             |  |                                                                     |  |                                           |  |                                |  |       |  |      |  |          |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|-------------------------------------------|--|--------------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                           |         | FIRST                                                                                                      |  | MIDDLE                                                                                                                                                      |  | LAST                                                                |  | 2a. DATE KNOWN<br>OF DEATH ESTI-<br>MATED |  | MONTH                          |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| Gladys                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                                                            |  |                                                                                                                                                             |  | Wright                                                              |  | xx                                        |  | 5                              |  | 20    |  | 19   |  | 86       |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4. RACE | 5. DATE OF BIRTH                                                                                           |  | 6. AGE (IN YEARS)                                                                                                                                           |  | IF UNDER 1 YR.                                                      |  | IF UNDER 24 HRS.                          |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| F                                                                                                                                                                                                                                                                                                                                                                                                                                             | B       | 12 17 15                                                                                                   |  | 70                                                                                                                                                          |  | YRS.                                                                |  |                                           |  | 5                              |  | 20    |  | 19   |  | 86       |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                  |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                           |  |                                |  |       |  |      |  |          |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                      |         | U.S.A.                                                                                                     |  |                                                                                                                                                             |  | Baltimore City                                                      |  |                                           |  |                                |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                     |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |                                           |  |                                |  |       |  |      |  |          |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                     |         | 410 North Duncan Street                                                                                    |  |                                                                                                                                                             |  |                                                                     |  |                                           |  |                                |  |       |  |      |  |          |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                    |         | 13b. COUNTY                                                                                                |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                       |  |                                |  |       |  |      |  |          |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                                                            |  | BALTIMORE                                                                                                                                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 410 DUNCAN STREET                         |  |                                |  |       |  |      |  |          |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                             |         | 15. MOTHER'S MAIDEN NAME                                                                                   |  |                                                                                                                                                             |  |                                                                     |  |                                           |  |                                |  |       |  |      |  |          |  |
| BENJAMIN                                                                                                                                                                                                                                                                                                                                                                                                                                      |         | MARY                                                                                                       |  |                                                                                                                                                             |  |                                                                     |  |                                           |  |                                |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                         |         | 16b. SOCIAL SECURITY NO.                                                                                   |  | 17. INFORMANT                                                                                                                                               |  | ADDRESS                                                             |  |                                           |  |                                |  |       |  |      |  |          |  |
| NO                                                                                                                                                                                                                                                                                                                                                                                                                                            |         | 218010145                                                                                                  |  | EARLINE FRALING                                                                                                                                             |  | 3023 LYTTLETON ROAD                                                 |  |                                           |  |                                |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |         |                                                                                                            |  |                                                                                                                                                             |  |                                                                     |  |                                           |  |                                |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.                                                                                                                                                                                                                                                                                                             |         |                                                                                                            |  |                                                                                                                                                             |  |                                                                     |  |                                           |  |                                |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                        |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                          |  | 20. AUTOPSY?                                                                                                                                                |  |                                                                     |  |                                           |  |                                |  |       |  |      |  |          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                            |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                         |  |                                                                     |  |                                           |  |                                |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                     |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                     |  |                                           |  |                                |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                                             |  | 21f. LOCATION<br>STREET                                                                                                                                     |  | CITY OR TOWN                                                        |  | COUNTY                                    |  | STATE                          |  |       |  |      |  |          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                            |  |                                                                                                                                                             |  |                                                                     |  |                                           |  |                                |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> (head only) Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                                                                                                            |  |                                                                                                                                                             |  |                                                                     |  |                                           |  |                                |  |       |  |      |  |          |  |
| ACTUAL<br>SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                           |         | TITLE (SPECIFY)<br>Assistant                                                                               |  | MEDICAL EXAMINER                                                                                                                                            |  | DATE<br>SIGNED                                                      |  | May 21, 86                                |  |                                |  |       |  |      |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                            |         | Gregory R. Kauffman, MD                                                                                    |  | ADDRESS                                                                                                                                                     |  | 111 Penn Street, Balto, MD 21201                                    |  |                                           |  |                                |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                  |         | 23b. DATE                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY                                    |  | STATE                          |  |       |  |      |  |          |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                        |         | 5-24-86                                                                                                    |  | MOUNT ZION                                                                                                                                                  |  | LANSOWNE                                                            |  |                                           |  | MARYLAND                       |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                          |         | 25a. DATE REC'D. BY REGISTRAR                                                                              |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |  |                                                                     |  |                                           |  |                                |  |       |  |      |  |          |  |
| WM.C.MARCH F/H INC. 1101 EAST NORTH AVENUE                                                                                                                                                                                                                                                                                                                                                                                                    |         | MAY 23 1986                                                                                                |  | John Gordon Handall                                                                                                                                         |  |                                                                     |  |                                           |  |                                |  |       |  |      |  |          |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

14331

|                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                      |                                                                                                                                                             |                                                                                       |                                                                                                                               |                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Gladys D. Wright</i>                                                                                                                                                                                                                                                         |                                                                                                                                                      |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>5-22-86</i>                                    |                                                                                                                               | 2b. HOUR<br><i>8:14 P.M.</i>                                                                    |
| 3. SEX<br><i>F</i>                                                                                                                                                                                                                                                                                                                       | 4. RACE<br><i>N</i>                                                                                                                                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>12 20 32</i>                                                                                                       |                                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>53</i> YRS.                                                                             | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY, MD.</i>                    |                                                                                                                               |                                                                                                 |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>                                                                                                                                                                                                                                                                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>SOUTH BALTIMORE GENERAL HOSPITAL</i> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>UNEMPLOYED</i> |                                                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>                                                                                                                                                                                                            |                                                                                                                                                      | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br><i>Baltimore</i>                                                 |                                                                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Clyde B. Powell</i>                                                                                                                                                                                                                                                                         |                                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Annie Terry</i>                                                                                         |                                                                                       |                                                                                                                               |                                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>                                                                                                                                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>213-26-3045</i>                                                                        | 17. INFORMANT (FREELAND) ADDRESS<br><i>Paula Powell 5802 Belle Grove Road</i>                                                                               |                                                                                       |                                                                                                                               |                                                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Possible Cordial Arrest.</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Premature Ventricular Beats.</i>                    |                                                                                                                                                      |                                                                                                                                                             |                                                                                       |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a                                                                                                                                                                                                       |                                                                                                                                                      |                                                                                                                                                             |                                                                                       |                                                                                                                               |                                                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |                                                                                       |                                                                                                                               |                                                                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                       |                                                                                                                               |                                                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>19 81</i> , 19____, to <i>June 2, 1986</i> , that (I) (we) last saw the deceased alive on <i>19</i> ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |                                                                                                                                                      |                                                                                                                                                             |                                                                                       |                                                                                                                               |                                                                                                 |
| 22b. SIGNATURE<br><i>D. Sawtney</i>                                                                                                                                                                                                                                                                                                      |                                                                                                                                                      | 22c. ADDRESS<br><i>7422 BtABlnd Glen Burnie Md</i>                                                                                                          |                                                                                       | 22d. DATE SIGNED<br><i>5/23/86</i>                                                                                            |                                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><i>BURIAL</i>                                                                                                                                                                                                                                                                               |                                                                                                                                                      | 23b. DATE<br><i>5/27/86</i>                                                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mount Auburn Cemetery</i>                    |                                                                                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Md.</i>                             |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Martha Funeral Homes 1101 East North Avenue</i>                                                                                                                                                                                                                                               |                                                                                                                                                      |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 27 1986</i>                                   |                                                                                                                               |                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                      |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><i>Jane Davidson-Hopkins</i>                            |                                                                                                                               |                                                                                                 |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this paper. Page 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the need for a coronary inquest may be required.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                         |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                          |  | 8 6                                                                                                                                                         |  | 1 4 3 3 2                                                                                                                  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SOPHIE E. WYAND                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                               |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 16 86                                                                                                              |  | 2b. HOUR<br>2:59 (M)                                                                                                       |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>CAUCASIAN                                                                                                          |  | 5. DATE OF BIRTH<br>DAY MONTH YEAR<br>02 04 1899                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 (87) YRS.                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GSH of Baltimore |  | 12a. USUAL OCCUPATION<br>(IF WORKING LIFE)<br>HOUSEWIFE                                                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----                                                                                 |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                               |  | 13b. COUNTY<br>BALTIMORE                                                                                                                                    |  | 13c. CITY OR TOWN<br>BALTIMORE                                                                                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>----- BROWN                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>-----                                                                                                      |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220013556                                                          |  | 17. INFORMANT<br>ADDRESS<br>PHYLLIS WARD 2401 HUNT PLACE FALLSTON 21047                                                                                     |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MINUTES<br>YEARS |  |                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                                                                                                                                                                                                                                                                               |  |                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/16 19 86, to 5/16 19 86, that (I) (we) last saw the deceased alive on 5/16 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                |  |                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>David J. Penn MD                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                               |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>5/16/86                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Penn                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                               |  | 22e. ADDRESS<br>Good Samaritan Hospital Baltimore                                                                                                           |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br>05/19/86                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDEN SOF FAITH                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. BALTO. MD.                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. J. Conk                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 19 1986                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>J. J. Conk                                                                                   |  |
| ADDRESS<br>1211 Chesapeake Ave.                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                            |  |

50930-01



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-06957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then file original with coroners papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or death is due to a traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |  | REG. NO. 86 14333                                                                                                                                          |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOHN W. WYCKOFF                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 16 86<br>2b. HOUR<br>1:30 A.M.                                                                                    |  |                                                                                                                            |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4 RACE<br>White                                                                                                                |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 14 16                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>425 South Parrish |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Shipping Clerk                                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Shipping                                                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore                                                                                                                                                                                                                                                                                 |  |                                                                                                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                            |  |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John W Wyckoff                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice Buck                                                                                                |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-09-5893                                                         |  | 17. INFORMANT<br>ADDRESS<br>Eleanor Wyckoff 425 S. Parrish St. 21223                                                                                       |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Squamous Ca of Lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 months</u> |  |                                                                                                                                |  |                                                                                                                                                            |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>Coronary ischemic disease</u>                                                                                                                                                                                                                                                                        |  |                                                                                                                                |  |                                                                                                                                                            |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                                                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>2-1</u> , 19 <u>86</u> , to <u>5-16</u> , 19 <u>86</u> , that (I) (myself) last saw the deceased alive on <u>4-9</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                         |  |                                                                                                                                |  |                                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Mark Gormley</u>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br><u>5/16/86</u>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Gormley, Mark</u>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                |  | 22e. ADDRESS<br>St. Agnes Hospital                                                                                                                         |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br>5/19/86                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk.                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Co Md.                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue 21229                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                |  | 25. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><u>5/19/86</u>                                                                                |  |                                                                                                                            |  |

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NOV 19 1964

MAINTENANCE

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20% COTTON FIBER

0-07874

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. The funeral director should remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury or her traumatic event, the medical examiner must be notified and once

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                            |  | REG. NO. 86 14334                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 1. DECEASED NAME (TYPE OR PRINT)                                                                       |  | FIRST MIDDLE LAST                                                                                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                             |  | 2b. HOUR                                                                                                                                   |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | REGINALD YARBROUGH                                                                                     |  |                                                                                                                                                          |  | May 18, 1986                                                                                 |  | 11:56a                                                                                                                                     |  | M                                            |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                              |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                                                |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | Black                                                                                                  |  | 10 21 1912                                                                                                                                               |  | 73 YRS.                                                                                      |  |                                                                                                                                            |  |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                         |  |                                                                                                                                            |  |                                              |  |
| North Carolina                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | U.S.A.                                                                                                 |  |                                                                                                                                                          |  | BALTIMORE CITY                                                                               |  |                                                                                                                                            |  | MD.                                          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |  |                                                                                                                                            |  |                                              |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | VA MEDICAL CENTER BALTIMORE MD                                                                         |  | Retired                                                                                                                                                  |  | Bethlehem Steel                                                                              |  |                                                                                                                                            |  |                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE                                                                                                             |  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | Baltimore                                                                                                                                                |  |                                                                                              |  | 660 Pitcher St. 21217                                                                                                                      |  |                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                             |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                            |  |                                              |  |
| Reginald Yarbrough                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Nellie Osten                                                                                           |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                            |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                                                      |  |                                                                                                                                            |  |                                              |  |
| Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | WW II                                                                                                  |  | 216-01- 9348                                                                                                                                             |  | Estella Yarbrough 660 Pitcher St. 21217                                                      |  |                                                                                                                                            |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                            |  | 2-86                                         |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Lung Cancer</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                            |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                            |  |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                            |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                                                                                              |  |                                                                                                                                            |  |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                              |  |                                                                                                                                            |  |                                              |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 17</u> , 19 <u>86</u> , to <u>May 18</u> , 19 <u>86</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>May 18</u> , 19 <u>86</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                            |  |                                              |  |
| 22b. SIGNATURE Jane Quinn M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  | DEGREE                                                                                                                                     |  | 22c. DATE SIGNED 5-18-86                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jane Quinn M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                              |  |
| 22e. ADDRESS 3900 Loch Raven Blvd. Baltimore Md 21218                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                                            |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                      |  |                                                                                                                                            |  |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5-23-86                                                                                                |  | Garrison Forest Veteran Cem.                                                                                                                             |  | Owings Mills, MD                                                                             |  |                                                                                                                                            |  |                                              |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR                                                                |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                 |  |                                              |  |
| Bailey Funeral Home 1348 N. Calhoun St. 21217                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  | MAY 28 1986                                                                                  |  |                                                                                                                                            |  |                                              |  |

MEDICAL CERTIFICATION

UNCLASSIFIED

2001 11 10 10:03

UNCLASSIFIED



00-06730

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

14335

|                                                                                          |                                                                                                                                       |                                                                                                                                                             |                                                                                                 |                                                                   |                                                                  |
|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>MELVIN</u> <u>YARLICK</u> |                                                                                                                                       |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>5-15-86</u>                                           |                                                                   | 2b. HOUR<br>MIN.<br><u>5:20</u> <u>A</u> <u>M</u>                |
| 3. SEX<br><u>MALE</u>                                                                    | 4. RACE<br><u>WHITE</u>                                                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>3</u> <u>6</u> <u>14</u>                                                                                           |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>72</u> YRS.                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MARYLAND</u>                             | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY</u> MD. |                                                                  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTO.</u>                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>LUTHERAN Hospital</u> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>MECHANIC</u>             | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>AUTO.</u>                 |                                                                  |
| 13a. STATE<br><u>MD.</u>                                                                 |                                                                                                                                       | 13b. CITY OR TOWN<br><u>ESSEX</u>                                                                                                                           | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><u>UNKNOWN</u> <u>21221</u>     |                                                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>JOSEPH</u> <u>VARLICK</u>                   |                                                                                                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>JENNIE</u> <u>BERMAN</u>                                                                                |                                                                                                 |                                                                   |                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>        | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><u>217-036635A</u>                                                         | 17. INFORMANT<br>ADDRESS<br><u>DANIEL YARLICK 6 Stonehenge Circle 21208</u>                                                                                 |                                                                                                 |                                                                   |                                                                  |

|                                                                                                                                                                                                                                                                                 |  |                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>sepsis</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a                                                                                                                                              |  |                                                 |

|                                                                                                                                                                                                                                                                                                                                                                         |                                                                          |                                                                                                                                                      |  |                                                                                      |                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                  |                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                       |  |                                                                                      |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                      |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-30</u> , 19 <u>86</u> , to <u>5-15</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>5-15-</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                                                          |                                                                                                                                                      |  |                                                                                      |                                                                                                                               |
| 22b. SIGNATURE<br><u>Matthew</u>                                                                                                                                                                                                                                                                                                                                        |                                                                          | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>5-15-86</u>                                                   |                                                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>A. Mathere</u>                                                                                                                                                                                                                                                                                                              |                                                                          | 22e. ADDRESS<br><u>730 Ashburton St. Baltimore - MD.</u>                                                                                             |  |                                                                                      |                                                                                                                               |

|                                                                 |                             |                                                            |                                                                                |
|-----------------------------------------------------------------|-----------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>BURIAL</u>   | 23b. DATE<br><u>5/15/86</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>CHUZIC AMUND</u>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BALTIMORE</u> <u>MARYLAND</u> |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>HEBREW MEMORIAL F.H. INC</u> |                             | ADDRESS<br><u>1100 REISTERSTOWN RD</u>                     | 25a. DATE REC'D. BY REGISTRAR<br><u>MAY 16 1986</u>                            |
|                                                                 |                             | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u> |                                                                                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a certifying physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



08130

2-12-21-2



00-06725

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 4 3 3 6  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             |                                                                        |                                                                                                                                                              |                                                          |                                                                                                                                                      |                                                              |                                                                                                                            |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>RICHARD YATES                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 14 86                         |                                                                                                                                                              |                                                          | 2b. HOUR<br>11:43P <sub>M</sub>                                                                                                                      |                                                              |                                                                                                                            |                                              |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>BLACK                                                                                                                            |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov 30 1915                                                                                                            |                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS                                                                                                            |                                                              | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                              |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                                                                                                                                                                                                                                                                                  |  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                       |                                                                        | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                          | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                                          |                                                              |                                                                                                                            |                                              |
| 12. CITY OR TOWN OF DEATH<br>Balt.                                                                                                                                                                                                                                                                                                                                                                               |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC, BALTIMORE MARYLAND 21218 |                                                                        |                                                                                                                                                              |                                                          | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Attendant                                                                         |                                                              | 15. KIND OF BUSINESS OR INDUSTRY<br>Garage                                                                                 |                                              |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY<br>Balt.                                                                                                                        |                                                                        | 13c. CITY OR TOWN<br>BALTO                                                                                                                                   |                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                      |                                                              | 13e. STREET ADDRESS / ZIP CODE<br>3215 Belton James Pl. 21230                                                              |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard Yates                                                                                                                                                                                                                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lina Smith                                                                                 |                                                                        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>yes WW II                                                    |                                                          | 16b. SOCIAL SECURITY NO.<br>227-12-6126                                                                                                              |                                                              | 17. INFORMANT<br>ADDRESS<br>Charmaine Price 3215 Belton James Pl                                                           |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY INSUFFICIENCY</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF LUNG</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>SMOKING</u>                      |  |                                                                                                                                             |                                                                        |                                                                                                                                                              |                                                          |                                                                                                                                                      |                                                              |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                             |  |                                                                                                                                             |                                                                        |                                                                                                                                                              |                                                          |                                                                                                                                                      |                                                              |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                              |                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                            |                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                         |  |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                              |                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                              |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                              |                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                              |                                                                                                                            |                                              |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/14, 19 86, to 5/14, 19 86, that <input checked="" type="checkbox"/> (we) lost the deceased alive on 5/14, 19 86, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated <del>other (b) (we) (did) (not) view the body after death.</del> |  |                                                                                                                                             |                                                                        |                                                                                                                                                              |                                                          |                                                                                                                                                      |                                                              |                                                                                                                            |                                              |
| 22b. SIGNATURE<br>Romanosky MD PhD                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                             |                                                                        |                                                                                                                                                              |                                                          | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                              | 22c. DATE SIGNED<br>16 MAY 86                                                                                              |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROMANOSKY                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                             |                                                                        |                                                                                                                                                              |                                                          | 22e. ADDRESS<br>3900 LOCH RAVEN BLVD. BALTIMORE MARYLAND                                                                                             |                                                              |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(BY)                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                             | 23b. DATE<br>5-19-86                                                   |                                                                                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br>Rocky Gap Vet Cem. |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland Md. |                                                                                                                            |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Carlton C. Douglass                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             |                                                                        |                                                                                                                                                              |                                                          | 25a. DATE REC'D. BY REGISTRAR<br>MAY 16 1986                                                                                                         |                                                              | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson                                                                               |                                              |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

Handwritten notes and signatures, including a large signature at the bottom left.



00-06172

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

14337

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                   |                                                                                                                                                    |                                                                                                                                                            |                                                                                                |                                                                 |
|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>GERALD E YINGER</b>                      |                                                                                                                                                    | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 8 1986</b>                                                                                                      |                                                                                                | 2b HOUR<br><b>1:28 <sup>a</sup></b>                             |
| 3 SEX<br><b>Male</b>                                                              | 4 RACE<br><b>White</b>                                                                                                                             | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 27, 1925</b>                                                                                               | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS                                                |                                                                 |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                   | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                       | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |                                                                 |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC BALTIMORE, MARYLAND 21218</b> | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self-employed</b>                                                                    | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Furniture Bus.</b>                                      |                                                                 |
| 13a STATE<br><b>Pennsylvania</b>                                                  | 13b COUNTY<br><b>York</b>                                                                                                                          | 13c CITY OR TOWN<br><b>York</b>                                                                                                                            | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE<br><b>819 W. Poplar St. 17404</b> |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Garrett Yinger</b>                    |                                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Beulah Crumbling</b>                                                                                   |                                                                                                |                                                                 |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b> | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 190 12 1230</b>                                                                  | 17 INFORMANT ADDRESS<br><b>Gloria A. Yinger - Same as #13e</b>                                                                                             |                                                                                                |                                                                 |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):  
PART I. DEATH WAS CAUSED BY

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHIMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) **Atherosclerotic Coronary Artery Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Numerous Episodes of Ventricular Fibrillation**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                      |                                                                                     |                                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                      | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                               | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                     | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |                                                                                                                              |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                            | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                              |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MAY 6</b> , 19 <b>86</b> , to <b>MAY 8</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>MAY 8</b> , 19 <b>86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (not) view the body after death. |                                                                                                                                                      |                                                                                     |                                                                                                                              |
| 22b SIGNATURE<br><b>Mary T Behrens</b>                                                                                                                                                                                                                                                                                                                                                                                                | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c DATE SIGNED<br><b>5-9-86</b>                                                    |                                                                                                                              |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mary T Behrens</b>                                                                                                                                                                                                                                                                                                                                                                         | 22e ADDRESS<br><b>3900 Loch Raven Blvd. Baltimore Md</b>                                                                                             |                                                                                     |                                                                                                                              |

|                                                                      |                                                   |                                                                    |                                                                      |
|----------------------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>         | 23b DATE<br><b>5-12-86</b>                        | 23c NAME OF CEMETERY OR CREMATORY<br><b>Prospect Hill Cemetery</b> | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>York York Penna.</b> |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b> | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b> | 25a DATE REC'D. BY REGISTRAR<br><b>MAY 12 1986</b>                 | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

00-06117

|                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                          |  |                                                                 |                                                              |  |                                                                                      |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|-----------------------------------------------------------------|--------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                        |  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                          |  |                                                                 | 86                                                           |  | 14338                                                                                |  |                                                                                                                            |  |
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                      |  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                          |  |                                                                 | REG. NO.                                                     |  |                                                                                      |  |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Jacob E Young Jr.                                                                                                                                                                                                                                                                                                                                  |  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                          |  |                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 7 86                |  | 2b. HOUR<br>400 A M                                                                  |  |                                                                                                                            |  |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                                 |  |  | 4. RACE<br>W                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 24 22                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN. |                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Maryland                                                                                                                                                                                                                                                                                                                                                               |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.               |  |                                                                 |                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                      |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Loch Raven VA Hospital |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Rod Man |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Iron Work                  |                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 13a. STATE<br>Md                                                                                                                                                                                                                                                                                                                                                                                            |  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                          |  |                                                                 | 13b. COUNTY<br>--                                            |  | 13c. CITY OR TOWN<br>Baltimore                                                       |  |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jacob E. Young, Sr.                                                                                                                                                                                                                                                                                                                                               |  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                          |  |                                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elsie Mason |  |                                                                                      |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>yes                                                                                                                                                                                                                                                                                                                                    |  |  | 16b. SOCIAL SECURITY NO.<br>WW II 214-12-1171                                                                                    |  | 17. INFORMANT<br>Katherine Young                                                                                                                            |  | ADDRESS<br>4412 Clydesdale Ave. 21211                                    |  |                                                                 |                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Respiratory Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Adenocarcinoma of Lung 6 months<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                          |  |                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |  |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                      |  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                          |  |                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                       |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                          |  |                                                                 |                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                              |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                          |  |                                                                 |                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 5-4 19-86, to 5-7 19-86, that (1) (we) lost saw the deceased alive on 5-6 19-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)                                                                                                         |  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                          |  |                                                                 | 22c. DATE SIGNED<br>5-7-86                                   |  |                                                                                      |  |                                                                                                                            |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jane A Quinn MD                                                                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                          |  |                                                                 | 22e. ADDRESS<br>3900 Loch Raven Blvd. Baltimore Md           |  |                                                                                      |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(Specify)                                                                                                                                                                                                                                                                                                                                                                |  |  | 23b. DATE<br>05/09/86                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Memorial Park                                                                                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westview, Balto. Co. Md    |  |                                                                 |                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Burgee-Henss Funeral Home, 3631 Falls rd. 21211                                                                                                                                                                                                                                                                                                                             |  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                          |  |                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>MAY 9 1986                  |  | 25b. REGISTRAR'S SIGNATURE                                                           |  |                                                                                                                            |  |

00-00115

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00-08126

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 14339  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |                                                                        |                                                                                                                                                                |                                                                               |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                                   |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Janie (JANNIE) Young</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05/29/1986</b>               |                                                                                                                                                                |                                                                               | 2b. HOUR<br><b>10: A M</b>                                                                                                                 |                                                                                                 |                                                                                                                            |                                                                                   |  |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>Black</b>                                                                                                                  |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04/ 06/1895</b>                                                                                                       |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS                                                                                           |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                        |                                                                                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> XX<br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                          |                                                                                                 |                                                                                                                            |                                                                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Melchor Nursing Home</b> |                                                                        |                                                                                                                                                                |                                                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>domestic</b>                                                        |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                                                   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                          | 13b. COUNTY<br><b>Baltimore</b>                                        |                                                                                                                                                                | 13c. CITY OR TOWN<br><b>Baltimore</b>                                         |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br><b>2422 E. Hoffman St. Baltimore, Md. 21213</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EDMOND</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MAE HALL</b>                                                                                               |                                                                               |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                                                                                                                                                                                                                |  |                                                                                                                                          | 16b. SOCIAL SECURITY NO.<br><b>213-07-4189</b>                         |                                                                                                                                                                | 17. INFORMANT<br>ADDRESS<br><b>DAVID LEE CHEATON JR. ROUTE 2 BOX 127 S.C.</b> |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cellulitis/Endocarditis</b>                                                                                                                                                                                                              |  |                                                                                                                                          |                                                                        |                                                                                                                                                                |                                                                               |                                                                                                                                            |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b>                                                            |                                                                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic lymphocytic leukemia</b>                                                                                                                                                                                                  |  |                                                                                                                                          |                                                                        |                                                                                                                                                                |                                                                               |                                                                                                                                            |                                                                                                 | Several years                                                                                                              |                                                                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |                                                                        |                                                                                                                                                                |                                                                               |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                          |  |                                                                                                                                          |                                                                        |                                                                                                                                                                |                                                                               |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                                   |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                                |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     |  |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                                |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                 |                                                                                                                            |                                                                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                    |  |                                                                                                                                          | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                                |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                 |                                                                                                                            |                                                                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 15</b> , 19 <b>86</b> , to <b>5/29</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/27</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                          |                                                                        |                                                                                                                                                                |                                                                               |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                                   |  |  |
| 22b. SIGNATURE<br><b>Man D. Sokolow</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          | DEGREE<br><b>MD</b>                                                    |                                                                                                                                                                |                                                                               | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>5/29/86</b>                                                                                         |                                                                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Man D. Sokolow, M.D.</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          | 22e. ADDRESS<br><b>333 St. Paul Place Balto Md 21202</b>               |                                                                                                                                                                |                                                                               |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                          | 23b. DATE<br><b>6/3/86</b>                                             |                                                                                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARMENIA BAPT. CH CEM</b>             |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CHESTER SC</b>                                 |                                                                                                                            |                                                                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WM. C. MARCH F/H INC. 1101 EAST NORTH AVENUE</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                          |                                                                        |                                                                                                                                                                |                                                                               |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                                   |  |  |
| 25a. DATE RECEIVED BY REGISTRAR'S SIGNATURE<br><b>JUN 2 1986</b> <b>Julia Davidson</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |                                                                        |                                                                                                                                                                |                                                                               |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                                                   |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page 4.



00-05888

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                               |  |                                                                                                                              |  |                                                                                                                                                          |  |                                                                                |  |                                                                                              |  | 86                                                                                                                      |  | 14340 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|-------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                             |  | 2a. DATE OF DEATH                                                                                                            |  |                                                                                                                                                          |  |                                                                                |  |                                                                                              |  | 2b. HOUR                                                                                                                |  |       |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                   |  | FIRST <i>Marie</i>                                                                                                           |  | MIDDLE <i>Theresa</i>                                                                                                                                    |  | LAST <i>Ziethen</i>                                                            |  | MONTH <i>05</i> DAY <i>05</i> YEAR <i>86</i>                                                 |  | 11:15 PM                                                                                                                |  |       |  |
| 3. SEX <i>Female</i>                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE <i>White</i>                                                                                                         |  | 5. DATE OF BIRTH MONTH <i>6</i> DAY <i>10</i> YEAR <i>04</i>                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS                                  |  | IF UNDER 1 YEAR MONTHS DAYS                                                                  |  | IF UNDER 24 HRS. HOURS MIN.                                                                                             |  |       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>                                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.                 |  |                                                                                              |  |                                                                                                                         |  |       |  |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i>                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mercy Hospital</i> |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>Housework</i>                                           |  |                                                                                                                         |  |       |  |
| 13a. STATE <i>Maryland</i>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                              |  | 13b. COUNTY                                                                                                                                              |  | 13c. CITY OR TOWN <i>Baltimore</i>                                             |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE <i>621 South Eaton Street 21224</i>                                                      |  |       |  |
| 14. FATHER'S NAME FIRST <i>James</i> MIDDLE LAST <i>Graham</i>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i> MIDDLE LAST <i>Smith</i>                                                                                      |  |                                                                                |  |                                                                                              |  |                                                                                                                         |  |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>                                                                                                                                                                                                                                                                                        |  |                                                                                                                              |  | 16b. SOCIAL SECURITY NO. <i>216-54-4995</i>                                                                                                              |  | 17. INFORMANT ADDRESS <i>Alfred P. Ziethen 5541 Lanham Way 21206</i>           |  |                                                                                              |  |                                                                                                                         |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Intraabdominal Metastasis</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Colon Cancer</i><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                              |  |                                                                                                                                                          |  |                                                                                |  |                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                            |  |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                               |  |                                                                                                                              |  |                                                                                                                                                          |  |                                                                                |  |                                                                                              |  |                                                                                                                         |  |       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  |                                                                                |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  |                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |                                                                                              |  |                                                                                                                         |  |       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                             |  |                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |                                                                                              |  |                                                                                                                         |  |       |  |
| 21g. I certify that (1) this hospital attended the deceased from <i>4/28</i> 19 <i>86</i> to <i>5/5</i> 19 <i>86</i> , that (1) (we) last saw the deceased alive on <i>5/5/86</i> 19 <i>86</i> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death.                 |  |                                                                                                                              |  |                                                                                                                                                          |  |                                                                                |  |                                                                                              |  |                                                                                                                         |  |       |  |
| 22a. SIGNATURE <i>Dana S. Simpler</i> DEGREE                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                              |  | 22b. ADDRESS <i>MERCY HOSPITAL</i>                                                                                                                       |  |                                                                                |  | 22c. DATE SIGNED <i>5/5/86</i>                                                               |  |                                                                                                                         |  |       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DANA S. SIMPLER</i>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                              |  | 22e. ADDRESS <i>MERCY HOSPITAL</i>                                                                                                                       |  |                                                                                |  |                                                                                              |  |                                                                                                                         |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                              |  | 23b. DATE <i>5-8-86</i>                                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Eastwood, Balto., Co., Md.</i>                    |  |                                                                                                                         |  |       |  |
| 24. FUNERAL DIRECTOR <i>Charles S. Zeiler &amp; Son Inc.</i> ADDRESS <i>901 S. Conkling St.</i>                                                                                                                                                                                                                                                                    |  |                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR <i>MAY 7 1986</i>                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                                     |  |                                                                                              |  |                                                                                                                         |  |       |  |

BP



00-05839

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

14341

|                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                          |                                                      |                                                                                                                                                             |                                |                                                                                                                                                                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Robert Adam Zile</b>                                                                                                                                                                                                                     |  |                                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 1 86</b> |                                                                                                                                                             | 2b. HOUR<br><b>5 45</b><br>A M |                                                                                                                                                                                                                                                 |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>Caucasian</b>                                                                                                                              |                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 1 86</b>                                                                                                         |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>0</b>                                                                                                                                                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                                              |                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hospital</b>      |                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>                                                                             |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>                                                                                                                                                                                                   |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                           |  | 13b. COUNTY<br><b>Carroll</b>                                                                                                                            |                                                      | 13c. CITY OR TOWN<br><b>New Windsor</b>                                                                                                                     |                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Steven A. Zile</b>                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rhonda E. Mitter</b>                                                                                 |                                                      | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                            |                                | 17. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                                                                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory and Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Prematurity - previable infant</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>—</b> |  | 19. DATE OF OPERATION                                                                                                                                    |                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                              |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5:45 (E.T.) 5/1/86</b>                                                                                |                                | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>51186 5:35 am - 5:45 (E.T.) 5/1/86</b>                                                              |                                | 22a. I certify that (I) [this hospital] attended the deceased from <b>5/1/86 at 5:44</b> and that in (my) [our] opinion death occurred on the date and hour and from the causes stated above. (I) [we] did (did not) view the body after death. |  |
| 22b. SIGNATURE<br><b>Elaine Trogon</b>                                                                                                                                                                                                                                                                  |  | 22c. DATE SIGNED<br><b>5/1/86</b>                                                                                                                        |                                                      | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Trogon</b>                                                                                                      |                                | 22e. ADDRESS                                                                                                                                                                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                        |  | 23b. DATE<br><b>5-2-1986</b>                                                                                                                             |                                                      | 23c. NAME OF <del>CENETRY</del> CREMATORY<br><b>Security Process</b>                                                                                        |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>Catonsville, Balto., Md.</b>                                                                                                                                                                         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles W. Burrier, Jr., Sykesville, Md.</b>                                                                                                                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 05 1986</b>                                                                                                      |                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>                                                                                                          |                                |                                                                                                                                                                                                                                                 |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled out and detached for use as the burial-transit permit. Then please remove to the proper authorities. Page 5 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical attention must be noted.

42

Robert Allen

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

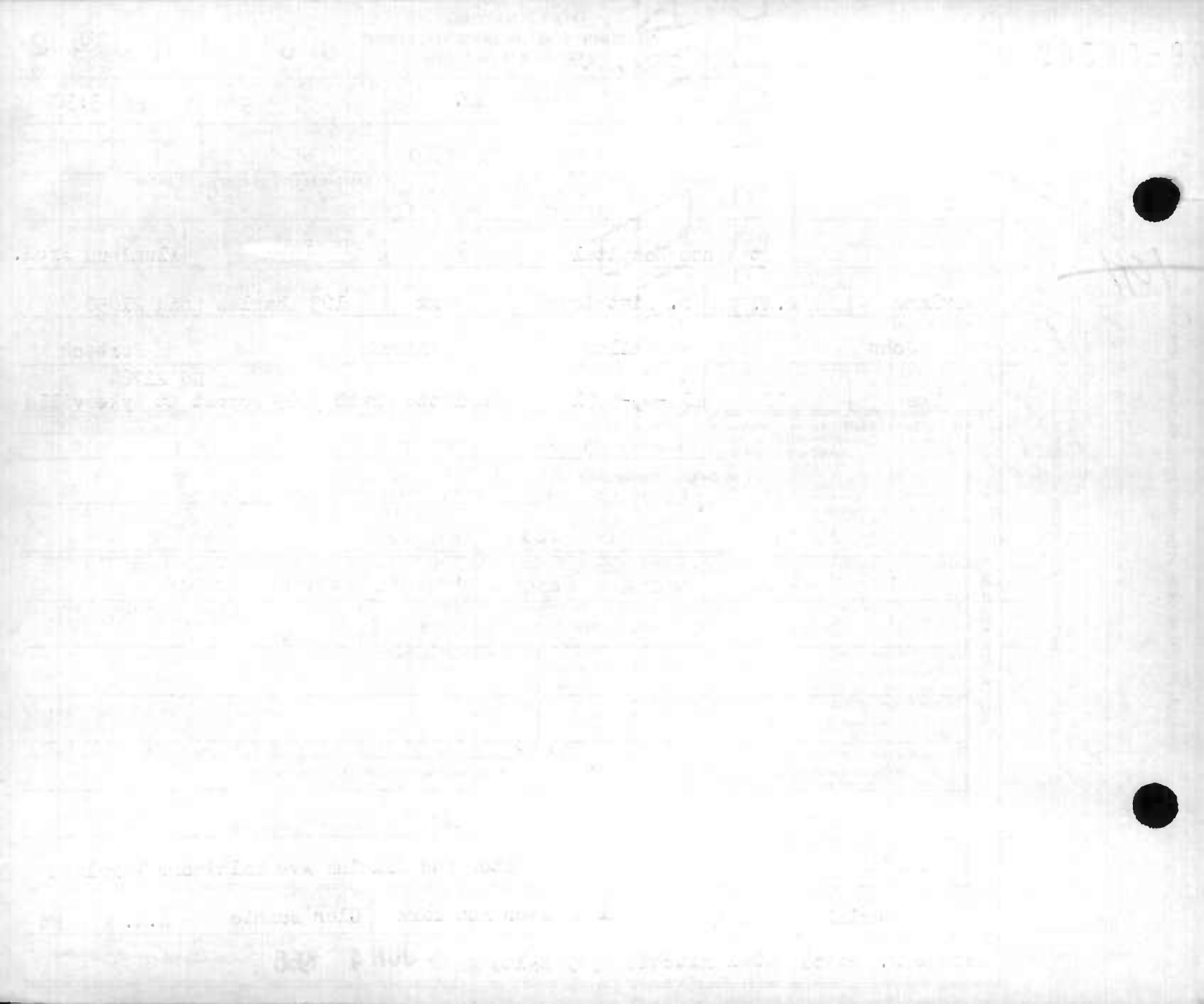
BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                    |  |                                                                                                           |  |                                                                                                                                                             |                                                                     |                                                                             |  |                                                                                |                            |                                                                |  |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------|--|--|--|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                          |  | BERNARD FRANCIS ZILER, SR.                                                                                |  |                                                                                                                                                             |                                                                     | 86 14342                                                                    |  |                                                                                |                            |                                                                |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                             |  | FIRST BERNARD MIDDLE Francis LAST ZILER Sr.                                                               |  |                                                                                                                                                             |                                                                     | 2a. DATE OF DEATH                                                           |  | MONTH DAY YEAR                                                                 |                            |                                                                |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                 |  |                                                                                                           |  |                                                                                                                                                             |                                                                     | 5 31 86                                                                     |  | 2b. HOUR 3:30P M                                                               |                            |                                                                |  |  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                          |  | 4. RACE                                                                                                   |  | 5. DATE OF BIRTH                                                                                                                                            |                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)                                             |  | IF UNDER 1 YEAR                                                                |                            |                                                                |  |  |  |  |
| MALE                                                                                                                                                                                                                                                                                                            |  | WHITE                                                                                                     |  | 10 MONTH 29 1920                                                                                                                                            |                                                                     | 65 YRS.                                                                     |  | MONTHS DAYS HOURS MIN.                                                         |                            |                                                                |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH                                        |  |                                                                                |                            |                                                                |  |  |  |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                       |  | USA                                                                                                       |  |                                                                                                                                                             |                                                                     | BALTIMORE CITY MD                                                           |  |                                                                                |                            |                                                                |  |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                             |                                                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR WHICH HE IS WORKING IF EMPLOYED) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                              |                            |                                                                |  |  |  |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                       |  | St Agnes Hospital                                                                                         |  |                                                                                                                                                             |                                                                     | Saw Operator                                                                |  | Aluminum Prod.                                                                 |                            |                                                                |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                    |  |                                                                                                           |  |                                                                                                                                                             | 13b. INSIDE CITY LIMITS?                                            |                                                                             |  |                                                                                |                            | 13c. STREET ADDRESS / ZIP CODE                                 |  |  |  |  |
| 13a. STATE Maryland 13b. COUNTY A.A. 13c. CITY OR TOWN N. Linthicum                                                                                                                                                                                                                                             |  |                                                                                                           |  |                                                                                                                                                             | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                             |  |                                                                                |                            | 103 Charles Road 21090                                         |  |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                               |  |                                                                                                           |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME                                            |                                                                             |  |                                                                                |                            |                                                                |  |  |  |  |
| FIRST John MIDDLE MIDDLE LAST Ziler                                                                                                                                                                                                                                                                             |  |                                                                                                           |  |                                                                                                                                                             | FIRST Mildred MIDDLE MIDDLE LAST Forbeck                            |                                                                             |  |                                                                                |                            |                                                                |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                            |  |                                                                                                           |  |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.                                            |                                                                             |  |                                                                                |                            | 17. INFORMANT ADDRESS                                          |  |  |  |  |
| Yes                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  |                                                                                                                                                             | WW II 219-03-9671                                                   |                                                                             |  |                                                                                |                            | Md 21784<br>Charlotte Grubb 5909 Forest Ct Sykesville          |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST                                                                                                                                                          |  |                                                                                                           |  |                                                                                                                                                             |                                                                     |                                                                             |  |                                                                                |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) PROLONGED REFRACTORY HYPOTENSION POST OP<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) MULTIPLE ORGAN FAILURE WITH DIC                                                                                                                                                         |  |                                                                                                           |  |                                                                                                                                                             |                                                                     |                                                                             |  |                                                                                |                            |                                                                |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>DIC, ARDS, ACUTE RENAL FAILURE, SEVERE ASCVD,                                                                                                                             |  |                                                                                                           |  |                                                                                                                                                             |                                                                     |                                                                             |  |                                                                                |                            |                                                                |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                     |                                                                             |  | 20a. AUTOPSY?                                                                  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |
| 5/29/86, 5/30/86                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  | ABDOMINAL AORTIC ANEURYSM                                                                                                                                   |                                                                     |                                                                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                        |  |                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                     |                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |                            |                                                                |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                       |  |                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                     |                                                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                            |                                                                |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/28 19 86, to 5/31 19 86, that (I) (we) last saw the deceased alive on 5/31 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                           |  |                                                                                                                                                             |                                                                     |                                                                             |  |                                                                                |                            |                                                                |  |  |  |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                                             |                                                                     | DEGREE                                                                      |  |                                                                                | 22c. DATE SIGNED           |                                                                |  |  |  |  |
| K. SHAH                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  |                                                                                                                                                             |                                                                     | MD                                                                          |  |                                                                                | 5/31/86                    |                                                                |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                           |  |                                                                                                           |  |                                                                                                                                                             |                                                                     | 22e. ADDRESS                                                                |  |                                                                                |                            |                                                                |  |  |  |  |
| K. SHAH                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  |                                                                                                                                                             |                                                                     | Caton and Wilkins Ave Baltimore Maryland                                    |  |                                                                                |                            |                                                                |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                    |  |                                                                                                           |  | 23b. DATE                                                                                                                                                   |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY                                          |  |                                                                                |                            | 23d. LOCATION                                                  |  |  |  |  |
| Burial                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | 6/4/86                                                                                                                                                      |                                                                     | Glen Haven Mem Park                                                         |  |                                                                                |                            | Glen Burnie CITY OR TOWN COUNTY A.A. STATE Md                  |  |  |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  |                                                                                                                                                             |                                                                     | 25a. DATE REC'D. BY REGISTRAR                                               |  |                                                                                | 25b. REGISTRAR'S SIGNATURE |                                                                |  |  |  |  |
| George J. Gonce 4001 Ritchie Hgwy Balto Md                                                                                                                                                                                                                                                                      |  |                                                                                                           |  |                                                                                                                                                             |                                                                     | JUN 4 1986                                                                  |  |                                                                                | John Davidson              |                                                                |  |  |  |  |

MEDICAL CERTIFICATION





0-08657

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8614343  
REG. NO.

|                                                                                                                                                                                                                                                                                                               |  |                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                     |                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                           |  | LOUIS T ZINSER                                                         |  | 2a. DATE OF DEATH                                                                                                                                           |  | MONTH DAY YEAR                                                      |  | 2b. HOUR P                                                          |                                                 |
|                                                                                                                                                                                                                                                                                                               |  |                                                                        |  | MAY 24,                                                                                                                                                     |  | 1986                                                                |  | 3:30 M                                                              |                                                 |
| 3. SEX                                                                                                                                                                                                                                                                                                        |  | 4. RACE                                                                |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                                                     |                                                 |
| Male                                                                                                                                                                                                                                                                                                          |  | White                                                                  |  | MONTH DAY YEAR<br>Sept. 30, 1924                                                                                                                            |  | 61                                                                  |  | MONTHS DAYS HOURS MIN.                                              |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                                                     |                                                 |
| Baltimore, Md.                                                                                                                                                                                                                                                                                                |  | U. S. A.                                                               |  |                                                                                                                                                             |  | BALTIMORE CITY MD                                                   |  |                                                                     |                                                 |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION                |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                                 |
| BALTIMORE                                                                                                                                                                                                                                                                                                     |  | THE JOHNS HOPKINS HOSPITAL                                             |  |                                                                                                                                                             |  | Sales man                                                           |  | Transportation                                                      |                                                 |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                       |  |                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                     |                                                 |
| 13a. STATE                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY                                                            |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. STREET ADDRESS / ZIP CODE                                      |  |                                                                     |                                                 |
| Maryland                                                                                                                                                                                                                                                                                                      |  | Baltimore                                                              |  | Kingsville                                                                                                                                                  |  | 12301 Jerusalem rd. 21087                                           |  |                                                                     |                                                 |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                             |  |                                                                        |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                    |  |                                                                     |  |                                                                     |                                                 |
| Louis J. Zinser                                                                                                                                                                                                                                                                                               |  |                                                                        |  | Grace Murray                                                                                                                                                |  |                                                                     |  |                                                                     |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                                                                                                                                  |  |                                                                        |  | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  | 17. INFORMANT ADDRESS                                               |  |                                                                     |                                                 |
| yes                                                                                                                                                                                                                                                                                                           |  |                                                                        |  | W. W. 11                                                                                                                                                    |  | Mrs. Edith Zinser, Kingsville, Md. 21087                            |  |                                                                     |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                      |  |                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cardiac arrest (asystole)                                                                                                                                                                                                                                                                 |  |                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                     | 2 minutes                                       |
| DUE TO, OR AS A CONSEQUENCE OF (b) Acidosis                                                                                                                                                                                                                                                                   |  |                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                     | 15 minutes                                      |
| DUE TO, OR AS A CONSEQUENCE OF (c) hemorrhagic pneumonitis                                                                                                                                                                                                                                                    |  |                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                     | 72 hours                                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                            |  |                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                     |                                                 |
| Aplasia, acute myelogenous leukemia                                                                                                                                                                                                                                                                           |  |                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                     |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |                                                                                                                                                             |  | 20a. AUTOPSY?                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                                 |
|                                                                                                                                                                                                                                                                                                               |  |                                                                        |  |                                                                                                                                                             |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                     |  |                                                                     |                                                 |
|                                                                                                                                                                                                                                                                                                               |  |                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                     |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |  |                                                                     |                                                 |
|                                                                                                                                                                                                                                                                                                               |  |                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                     |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-14, 19 86, to 5-24, 19 86, that (I) (we) lost<br>saw the deceased alive on 5-24, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If we) did not view the body after death. |  |                                                                        |  |                                                                                                                                                             |  |                                                                     |  |                                                                     |                                                 |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                |  |                                                                        |  | DEGREE                                                                                                                                                      |  |                                                                     |  | 22c. DATE SIGNED                                                    |                                                 |
| Frederick M. Gessner MD                                                                                                                                                                                                                                                                                       |  |                                                                        |  |                                                                                                                                                             |  |                                                                     |  | 5-24-86                                                             |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                         |  |                                                                        |  | 22e. ADDRESS                                                                                                                                                |  |                                                                     |  |                                                                     |                                                 |
| Frederick M. Gessner MD                                                                                                                                                                                                                                                                                       |  |                                                                        |  | 600 N. Wolfe St Balto Md 21205                                                                                                                              |  |                                                                     |  |                                                                     |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                  |  | 23b. DATE                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION                                                       |  |                                                                     |                                                 |
| Burial                                                                                                                                                                                                                                                                                                        |  | 5-29-1986                                                              |  | Bel Air Memorial Gar.                                                                                                                                       |  | Bel Air Harford Md.                                                 |  |                                                                     |                                                 |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                          |  |                                                                        |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                          |                                                 |
| E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087                                                                                                                                                                                                                                                          |  |                                                                        |  |                                                                                                                                                             |  | JUN 02 1986                                                         |  | Julia Darden-Randall                                                |                                                 |

MEDICAL CERTIFICATION

2

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician, it should be placed in the funeral director's file. The funeral director should be detached for use as the burial permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]*

1 10 12 015  
p 510 21 41

00-05937

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

14344

|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |                                                                           |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Helen C Ziolkowski</b>                                                                                                                                                                                                                                                            |  |                                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 7 86</b>                      |                                                                                                                                                             |  | 2b. HOUR<br><b>0046</b> M                                                                       |  |                                                                                                                            |                                              |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>W</b>                                                                                                                               |                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 09 11</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.                                               |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                     |                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital, Caton Ave</b> |                                                                           |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOME MAKER</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                              |
| 13a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY                                                                                                                                       |                                                                           | 13c. CITY OR TOWN<br><b>Balt</b>                                                                                                                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>632 Stanford Rd 21229</b>                                                             |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BENJAMIN GUTOWSKI</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                                   |                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |  |                                                                                                 |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                           |  |                                                                                                                                                   |                                                                           | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  | 17. INFORMANT ADDRESS<br><b>MARCELHA GOLLERY 632 STANFORD AVE</b>                               |  |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CAD, ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)                                                                 |  |                                                                                                                                                   |                                                                           |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                          |  |                                                                                                                                                   |                                                                           |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |  |                                                                                                                                                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4 19 86</b><br>P.M. |                                                                                                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                |  |                                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |                                                                                                                                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4 19 86</b> to <b>5 8 86</b> , that (I) (we) last saw the deceased alive on <b>4 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                   |                                                                           |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                              |
| 23a. SIGNATURE<br><b>Raymond L. Kaczorowski</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |                                                                           |                                                                                                                                                             |  | DEGREE                                                                                          |  | 23b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Raymond L. Kaczorowski</b>                                                     |                                              |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Raymond L. Kaczorowski</b>                                                                                                                                                                                                                                                      |  |                                                                                                                                                   |                                                                           |                                                                                                                                                             |  | 23d. ADDRESS<br><b>2525 Fleet St</b>                                                            |  | 23e. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1986</b>                                                                         |                                              |
| 23f. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>RAYMOND L. KACZOROWSKI 2525 FLEET ST</b>                                                                                                                                                                                                                                        |  |                                                                                                                                                   |                                                                           |                                                                                                                                                             |  | 23g. REGISTRAR'S SIGNATURE<br><b>John A. [Signature]</b>                                        |  | 23h. DATE SIGNED<br><b>5/5/86</b>                                                                                          |                                              |
| 23i. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                  |  |                                                                                                                                                   |                                                                           |                                                                                                                                                             |  | 23j. DATE<br><b>5/10/86</b>                                                                     |  | 23k. NAME OF CEMETERY OR CREMATORY<br><b>HOLY ROSARY</b>                                                                   |                                              |
| 23l. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                                   |                                                                           |                                                                                                                                                             |  | 23m. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1986</b>                                              |  | 23n. REGISTRAR'S SIGNATURE<br><b>John A. [Signature]</b>                                                                   |                                              |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

